

Arthurs

Family Dentistry

NEW PATIENT FORMS

(PLEASE PRINT CLEARLY)

Date: _____

PATIENT: _____ PREFERS: _____

LAST, FIRST, MI

GENDER: F / M MARTIAL STATUS: SINGLE / MARRIED / OTHER SOCIAL SECURITY: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

WHAT PHONE NUMBER IS BEST TO GET A HOLD OF YOU DURING THE DAY? _____ HOME _____ CELL _____ WORK

IS IT OK TO SEND TEXT MESSAGES? YES NO

ADDRESS: _____ CITY _____ STATE _____ ZIP _____

BIRTH DATE: _____ EMAIL: _____

DRIVERS LICENSE: _____

How were you referred to our practice?

What is the most important thing to you about your dental visit today?

What are the most important things to you about your smile and dental health?

Please check if any of the following problems apply to you:

- | | | |
|--|--|---|
| <input type="checkbox"/> Sensitivity (hot, cold or sweets) | <input type="checkbox"/> Grinding or clenching teeth | <input type="checkbox"/> Teeth or fillings breaking |
| <input type="checkbox"/> Headaches or earaches | <input type="checkbox"/> Bleeding, swollen or irritated gums | <input type="checkbox"/> Bad Breath/Dry Mouth |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Loose, tipped or shifting teeth | <input type="checkbox"/> Other pain/discomfort: |

Do you have or have you had any of the following:

- | | |
|---|-------------------|
| <input type="checkbox"/> Dentures | How old are they? |
| <input type="checkbox"/> Partial Dentures | How old are they? |
| <input type="checkbox"/> Periodontal gum treatments | How long ago? |

Please share the following approximate dates:

Your last cleaning

Your last oral cancer screening

Your last complete x-rays

- | | | | | |
|---------|--|---------------------------------------|---------------------------------------|---|
| Tobacco | Do you use tobacco? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| | <input type="checkbox"/> Cigarettes - pks./day | <input type="checkbox"/> Chew - #/day | <input type="checkbox"/> Pipe - #/day | <input type="checkbox"/> Cigars - #/day |
| | <input type="checkbox"/> # of years | <input type="checkbox"/> Or year quit | | |

If you could change your smile, would you: (Please check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Make your teeth whiter | <input type="checkbox"/> Replace black metal fillings w/ white filling | <input type="checkbox"/> Replace old crowns that don't match |
| <input type="checkbox"/> Make your teeth straighter | <input type="checkbox"/> Repair chipped teeth | <input type="checkbox"/> Have a smile makeover |
| <input type="checkbox"/> Close spaces between teeth | <input type="checkbox"/> Replace missing teeth | <input type="checkbox"/> Other: |

On a scale of 1 to 5, with 5 being the highest rating: (please circle the numbers that best applies)

- | | | | | | |
|---|---|---|---|---|---|
| How important is your dental health to you? | 1 | 2 | 3 | 4 | 5 |
| I want to keep my teeth and improve my smile, but have certain time and money concerns. | 1 | 2 | 3 | 4 | 5 |

Full payments are due and payable on the day of your dental visit. Please indicate which payment options you prefer when paying for your dental services or which payment options you'd like to learn more about: (Please check all that apply) (subject to insurance requirements)

- Cash (10% Discount) Check Major Credit Card Care Credit Financing Custom In-office Payment Plan to meet your needs

MEDICAL HEALTH HISTORY

PLEASE SELECT YES OR NO			
Are you taking any Medications			<input type="checkbox"/> Yes <input type="checkbox"/> No
List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers			
Drug:	Drug:	Drug:	
Are any of these medications for bone density?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Are any of these medications blood thinners?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to medications, substances, anesthetic, latex, metals?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy:	Allergy:	Allergy:	
For Women Only: Do you suspect you may be pregnant?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Health: Are you treated for or advised of Heart disease?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Pacemaker, artificial heart valve, heart murmur?			<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure?			<input type="checkbox"/> Yes <input type="checkbox"/> No
GENERAL			
Major Surgeries			<input type="checkbox"/> Yes <input type="checkbox"/> No
Surgery:	Surgery:	Surgery:	
Do you have any artificial joint/prosthesis or hardware?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you a diabetic?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had radiation treatment, chemotherapy?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberculosis?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have stomach problems? (ie: heartburn, acid reflux, GERD, etc.)			<input type="checkbox"/> Yes <input type="checkbox"/> No
Inflammatory disease such as arthritis or rheumatism?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any kidney problems?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any liver problems?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have asthma?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you or have you had any sexually transmitted diseases?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia, leukemia. Etc.?			<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV/AIDS?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you test positive for Hepatitis?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Excessive bleeding after being cut or injured?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever received a blood transfusion?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Consume alcoholic beverages?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you habitually use controlled substances or have you in the past?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any health problems that need further clarification?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Please explain:			

I acknowledge the information in the Medical History to be correct and current.

I have received a copy of Arthurs Family Dentistry's "Our Commitments" form. I have read and thoroughly understand all the statements on the form.

X _____ Date: _____ Relation to Patient: _____
 Signature of patient, parent or guardian

Release & Financial Policies:

- Full payments for services are due and payable on the day of my dental visit when treatment is started.
- I understand that all dental services furnished are charged directly to me as the patient regardless of insurance.
- I accept responsibility for past due and unpaid balances including; fees, penalties, interest, court costs and retrieval/posting of credit report information.
- I understand that my dental benefit plan is a contract between me and my insurance company, **Arthurs Family Dentistry** is not part of that contract.
- I understand that some necessary treatments are not covered benefits under some plans.
- As a courtesy: **Arthurs Family Dentistry** will complete and mail my insurance claim forms.
- If your insurance does not accept assignment of benefits full payment will be collected day of appointment. Reimbursements are sent to these patients.
- I agree that if my insurance payment comes to **Arthurs Family Dentistry** and leaves a balance, **Arthurs Family Dentistry** may charge the remaining balance due to my credit card on file.
- This office has a 48-hour cancellation policy. If the cancellation is made after the 48-hour deadline, **Arthurs Family Dentistry** reserves the right to charge me a fee for the lost time.
- If a refund is requested, there will be an 8 to 12 week processing timeframe before checks would be received.
- If I was formerly a patient of record with a different dentist, I agree to and understand that all future care will be provided by **Arthurs Family Dentistry** and its providers and do not hold **Arthurs Family Dentistry** responsible for any care provided
- **There will be a \$50 penalty on all returned checks.**

I authorize the dentists and hygienists at Arthurs Family Dentistry to perform diagnostic procedures and treatment as necessary for proper dental care. I authorize and consent to photos and images to be taken and displayed for marketing and/or learning purposes. I hereby authorize 'Assignment of Benefit' by my insurance carrier and the release of any information concerning my (or my family's) health care, advice and treatment provided for the purpose of evaluation. By signing below, I agree to continue accepting financial responsibility for any and all services provided. I also verify that all the information on this form is current and accurate.

x My initial here acknowledges that, I understand Arthurs Family Dentistry abides by the HIPPA Law and will protect the privacy of my personal information.

Signature of patient, parent or guardian

Printed Name



Family Dentistry

NEW PATIENT FORMS

Emergency Contact Information:

x _____ Initial (here for us to talk with this person about you and your account.)

Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____ City _____ State _____ Zip _____

Relationship to patient: _____

Responsible Party: *(if different than patient)*

Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____ City _____ State _____ Zip _____

Date of Birth: _____ Social Security Number: _____ - _____ - _____

Driver's License Number: _____

Insurance Information

Employment: *(Of Responsible Party)*

Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____ City _____ State _____ Zip _____

Phone: _____ Occupation: _____

Insurance Primary plan:

Insured's Name: _____ Date of Birth: _____

Group Name (employer) : _____ Group or Account # _____

Member ID Number: _____

Insurance Company Name: _____

Claims Address: _____ City _____ State _____ Zip _____

Claims Phone: _____

Insurance Secondary plan:

Insured's Name: _____ Date of Birth: _____

Group Name (employer) : _____ Group or Account # _____

Member ID Number: _____

Insurance Company Name: _____

Claims Address: _____ City _____ State _____ Zip _____

Claims Phone: _____

Our Commitments

We feel it is important to share a few policies of our practice with you. We have put them in writing because we live by them and request that our patients live by them as well. We ask that you read this thoroughly to become familiar with them, then sign and date to indicate that you understand and agree to comply with them.

COMMITMENT TO TREATMENT POLICY

We believe that all treatment begun should be completed. Incomplete treatment leads to problems, complications, further disease, and more expenses. Therefore, if a plan is agreed upon and started, it needs to be completed. Rest assured that we would never move forward with treatment without your consent.

COMMITMENT TO APPOINTMENT POLICY

We reserve time for each patient in our practice and rarely keep patients waiting. An appointment written in our schedule with your name on it is a bond of trust that we will be here to serve you and that you will be present for that appointment. Our answering machine does not accept appointment cancellations or changes. We must have mutual respect for each other's time.

COMMITMENT TO FINANCIAL AGREEMENT POLICY

We believe we have a responsibility to you to use our best professional care, skill and judgment in planning and delivering your dental treatment. We can only fulfill this mission through a bond of trust with you to pay for services. We will do our best to make you aware of all fees before treatment is rendered.

INSURANCE POLICY

Our office does not diagnose, render treatment or establish fees according to any insurance tables or allowances. Our fees are based on the care, skill and judgment of the professionals delivering the services, and the cost of operating a dental office dedicated to excellence. Please remember that we work 100% for you, not your insurance company. Your dental plan may only cover charges for the least expensive results. We refuse to compromise our standards by offering anything less than the complete care that you deserve. Please understand that you are ultimately responsible for any amounts not covered by your plan.

**Thank you, we feel honored that you have
chosen us to service your dental needs.**