SAVE DENTAL

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL INFORMATION

Patient Name_____
Last First MI (Preferred)

Date of Birth _____ SS# _____ DL# _____ Gender: ☐ M ☐ F Married: ☐ Y ☐ N

Address _____ City _____ State_____ Zip _____

Home Phone _____ Mobile Phone _____ Email _____

Current Employer _____ Employer Phone # _____

How did you hear about us? ☐ Mailer ☐ Drive By ☐ Google ☐ Friend/Patient _____ ☐ Other _____

Preferred Appointment Confirmation Type: ☐ Text Message ☐ Phone Call ☐ Email

When was your last dental visit?_____

Reason for today's office visit? _____

Interested in teeth whitening? ☐ Yes ☐ No Interested in a straighter smile? ☐ Yes ☐ No Snore at night? ☐ Yes ☐ No

If patient is under 18 yrs, please also complete the following:

Guarantor Name _____
Last First MI (Preferred)

Date of Birth _____ SS# _____ DL# _____ Gender: ☐ M ☐ F Married: ☐ Y ☐ N

Address _____ City _____ State_____ Zip _____

Home Phone _____ Mobile Phone _____ Email _____

INSURANCE POLICY INFORMATION

Patient relationship to subscriber: ☐ Self ☐ Spouse ☐ Child *****PLEASE PRESENT YOUR DENTAL ID CARD*****

Subscriber Name _____ Sub.ID # _____ Sub.DOB_____

Insurance Company _____ Phone _____

Employer _____ Group Name _____ Group # _____

Is patient covered by another insurance? [ ] Y [ ] N

NO SHOW & CANCELLATION POLICY

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you. **We ask that if you must change an appointment, please give us at least 48 hours notice.** This courtesy makes it possible to give your reserved room to another patient on our waiting list, who would like it.

Save Dental charges $50.00 per hour for any no show or late cancellation of an office visit or hygiene visit. I understand that repeated cancellations or missed appointments will require me to pre pay ($50.00 per hour) for the appointment upon scheduling. I understand that if I fail to show up for my scheduled appointment or cancel less than 48 hours that pre paid amount becomes nonrefundable. _____

Initials

MEDICAL HISTORY

Name of Medical Doctor _____ City/State _____

Emergency Contact _____ Phone _____ Relationship _____

List all medications or drugs you are now taking:

☐ None

_____

_____

_____

Check medications or drugs you are allergic to:

☐ None
☐ Aspirin
☐ Codeine/ Other Narcotics
☐ Erythromycin
☐ Latex Rubber
☐ Local Anesthetics
☐ Metals
☐ Penicillin
☐ Sulfa Drugs
☐ Other _____

Check any medical conditions you may have:

☐ None
☐ AIDS/HIV
☐ Alcohol/Drug Abuse
☐ Anemia/Leukemia
☐ Anorexia/Bulimia
☐ Arthritis
☐ Asthma/Hay Fever
☐ Blood Clotting Problems
☐ Blood Transfusion
☐ Bronchitis
☐ Cancer/Tumor or Growth
☐ Cardiac Pacemaker
☐ Chest Pain Upon Exertion
☐ Damaged Heart Valve
☐ Other _____
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Fainting Spells/Seizures
☐ Fever Blisters/Herpes
☐ Frequent Headaches
☐ Frequently Dry Mouth/Sjogren
☐ Gall Bladder Trouble
☐ Heart Attack/Stroke
☐ Heart Disease/Angina
☐ Heart Murmur
☐ Hepatitis/Jaundice
☐ High Blood Pressure
☐ Hives/Skin Rash
☐ Joint Replacement, Date of _____
☐ Kidney/Bladder Trouble
☐ Liver Disease
☐ Low Blood Pressure
☐ Mental Health Problems
☐ Mitral Valve Prolapse
☐ Persistent Diarrhea
☐ Rheumatic Fever
☐ Rheumatic Heart Disease
☐ Sexually Transmitted Disease
☐ Sinus Trouble
☐ Stomach Ulcers
☐ Thyroid Problems
☐ Tuberculosis

Unusual reaction to dental injections or general anesthesia? ☐ Yes ☐ No
Does your doctor recommend you take pre-med with antibiotics prior to any dental treatment? ☐ Yes ☐ No
WOMEN ONLY- Are you pregnant or do you have reason to believe you may be? ☐ Yes ☐ No
Tobacco use? ☐ Yes ☐ No What kind & how much _____ Do you use recreational drugs? ☐ Yes ☐ No

Patient Agreement

Our office provides insurance billing as a courtesy to our patients. The patient portion of dental services is **estimated only** and not guaranteed. All patient portions are due at the time of service. This amount may be subject to adjustment when claims are adjusted by the insurance company. I understand that it is my responsibility to pay any deductible amount, co-insurance or any other balance not paid by my insurance company. I understand that I am solely responsible for monitoring my insurance plans limitations, coverage and benefits and it is not the responsibility of my dental care provider. I acknowledge that I am responsible for any and all balances due. If sent to collections, I agree to pay a 40% fee, all attorney fees, interest (1.8% monthly), and court costs accrued as a result of past due balances.

I agree to being contacted by phone, text messages or emails, using the information I have provided. I agree and understand that these methods of contact may be used in an attempt to collect any amounts owed, for scheduling and billing messages, or for other information deemed relevant to my patient care.

By signing below, I certify that all of the above information is true to the best of my knowledge.

I have read and received a copy of this office's Notice of Privacy Practices.

Patient/Guardian Signature _____ Date _____