

NEW PATIENT FORM

Name: _____ Date: _____

Preferred Name: _____ Gender: (male)____ (female)____ (other)____

DOB: _____ SSN #: _____ Email: _____

Street address: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Cell Phone: _____

Emergency Contact Name: _____ Phone: _____

Employer: _____ Work Phone: _____

Referred by: _____

INSURANCE INFORMATION

Name of Insured: _____ DOB: _____ Relationship to patient: _____

Insurance Company: _____ Policy/ID #: _____

Group/Employer Name: _____ Group #: _____

Ins. Co. Address: _____ Ins. Co. Phone #: _____

Secondary Insurance:

Name of Insured: _____ DOB: _____ Relationship to patient: _____

Insurance Company: _____ Policy/ID #: _____

Group/Employer Name: _____ Group #: _____

Ins. Co. Address: _____ Ins. Co. Phone #: _____

DENTAL HISTORY

Date of your last dental exam: _____ Date of your last cleaning: _____

Do you have any immediate concerns you'd like us to address? **Yes**____ **No**____

- If YES please explain: _____

On a scale from **1-5**, 5 being most terrified, are you fearful of dental treatment? _____

Please answer the following questions:

Are you concerned about the appearance of your teeth? **Yes**____ **No**____

Are you interested in improving your smile? **Yes**____ **No**____

Are any teeth currently sensitive to biting, sweets, hot, or cold? **Yes**____ **No**____

Do you avoid or have difficulty chewing or biting heavily any hard foods? **Yes**____ **No**____

Do you have any problems sleeping, wake up with a headache or with sore or sensitive teeth? **Yes**____ **No**____

Do you wear, or have you ever worn a bite appliance? **Yes**____ **No**____

Do your gums bleed when brushing/flossing? **Yes**____ **No**____ Is brushing or flossing typically painful? **Yes**____ **No**____

Have you ever been treated for or been told you have gum disease? **Yes**____ **No**____

Have you ever had braces, orthodontic treatment or spacers, or had a "bite adjustment?" **Yes**____ **No**____

MEDICAL HISTORY

Name of Physician: _____ Phone #: _____

Date of last Exam: _____ Are you under medical treatment now? _____

Are you currently taking any medications, supplements, or drugs? Yes _____ No _____

- If YES, please list here: _____

Have you ever been hospitalized for any surgical operation or serious illness within the last 5yrs? Yes _____ No _____

- If YES please explain: _____

Do you take, or have you ever taken Phen-Fen, Redux, Fosamax, Boniva, Actonel or any other bisphosphonate medications: Yes _____ No _____

Do you use tobacco? Yes _____ No _____

Are you allergic to any of the following?

Aspirin _____ Penicillin _____ Local Anesthetics _____ Acrylic _____ Metals _____ Latex _____ Sulfa Drugs _____

Do you have, or have you ever had, any of the following?

AIDS/HIV	Yes No	Heart Trouble/Disease	Yes No	Liver Disease	Yes No
Alzheimer's Disease	Yes No	Hepatitis A	Yes No	Low Blood Pressure	Yes No
Anaphylaxis	Yes No	Hepatitis B	Yes No	Lung Disease	Yes No
Anemia	Yes No	Hepatitis C	Yes No	Mitral Valve Prolapse	Yes No
Angina	Yes No	Herpes	Yes No	Osteoporosis	Yes No
Arthritis/Gout	Yes No	High Cholesterol	Yes No	Pain in Jaw Joints	Yes No
Artificial Heart Valve	Yes No	High Blood Pressure	Yes No	Parathyroid Disease	Yes No
Artificial Joint	Yes No	Hives or Rash	Yes No	Psychiatric Care	Yes No
Asthma	Yes No	Hypoglycemia	Yes No	Radiation Treatments	Yes No
Blood Disease	Yes No	Irregular Heartbeat	Yes No	Recent Weight Loss	Yes No
Blood Transfusion	Yes No	Kidney Problems	Yes No	Renal Dialysis	Yes No
Breathing Problem	Yes No	Epilepsy or Seizures	Yes No	Rheumatic Fever	Yes No
Bruise Easily	Yes No	Excessive Bleeding	Yes No	Rheumatism	Yes No
Cancer	Yes No	Excessive Thirst	Yes No	Scarlet Fever	Yes No
Chemotherapy	Yes No	Fainting Spells/Dizziness	Yes No	Shingles	Yes No
Chest Pains	Yes No	Frequent Cough	Yes No	Sickle Cell Disease	Yes No
Cold Sores	Yes No	Frequent Diarrhea	Yes No	Sinus Trouble	Yes No
Congenital Heart Disorder	Yes No	Glaucoma	Yes No	Spina Bifida	Yes No
Convulsions	Yes No	Growths of Tumors	Yes No	Stomach Problems	Yes No
Cortisone Medicine	Yes No	Hay Fever	Yes No	Stroke	Yes No
Diabetes	Yes No	Heart Attack/Failure	Yes No	Swelling of Limbs	Yes No
Drug Addiction	Yes No	Heart Murmur	Yes No	Thyroid Disease	Yes No
Easily Winded	Yes No	Heart Pacemaker	Yes No	Tonsillitis	Yes No
Emphysema	Yes No	Leukemia	Yes No	Tuberculosis	Yes No

Women: Pregnant/Trying to get pregnant? Yes _____ No _____ If YES, how many weeks? _____

Breast feeding? Yes _____ No _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect medical information can be dangerous to me and my health. It is my responsibility to inform the dental office of any changes in medical status.

Patient Signature

(Parent/Guardian): _____ **Date:** _____

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

INSURANCE: Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf. Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT: Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

UNPAID BALANCE over 90 days old will be subject to a monthly interest of 1.0% (APR 12%). If payment is delinquent, the patient will be responsible for payment of collection, attorneys fees, and court costs associated with the recovery of the monies due on the account.

MISSED APPOINTMENTS: Unless we receive notice of cancellation 48 hours in advance, you will be charged \$50. Please help us maintain the highest quality of care by keeping scheduled appointments. I have read, understand and agree to the terms and conditions of this Financial Agreement.

Patient's signature:

Date

COMMUNICATION CONSENTS

EMAIL CONSENT FORM PURPOSE:

This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. Pearl Dentistry offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. Pearl Dentistry will use reasonable means to protect the security and confidentiality of email information sent and received. However, Pearl Dentistry cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between Pearl Dentistry and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Pearl Dentistry.

Patient's signature: _____

Date: _____

TEXT MESSAGE TO MOBILE CONSENT FORM PURPOSE:

This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. Pearl Dentistry offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. Pearl Dentistry will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Pearl Dentistry cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between Pearl Dentistry and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Pearl Dentistry.

Patient's signature: _____

Date: _____