Patient Information

Save some time and upload your **Photo ID or Driver's License** instead.

Let's go →

Basic Information

First Name *

Last Name *

Preferred Name

Date of Birth (MM/DD/YYYY) *

MM/DD/YYYY

Gender *

Mobile Phone *

(___) ___-____

Home Phone

(___) ___-____

Email Address *

Family Status

Family Status *

Address

Type in to search your address

Address Line 1 *

Address Line 2

City *

State *

Zip *

Referral Information

How did you hear about us?

Contacts

Responsible Party

What is your relationship to the patient?

I am the patient

Someone else

Emergency Contact

Name *

Phone *

(___) ___-____

Relationship

Dental Insurance

Do you have dental insurance?

Yes

No

Dental History

What is the primary reason for your visit? *

Previous Dentist Name & Phone Number

When was your last dental visit? *

Please check all that apply *

- ☐ Adverse reaction or complication from past dental treatment
- ☐ Difficulty getting numb for dental procedures
- ☐ Teeth sensitive to hot, cold, sweets, or pressure
- ☐ Current or past orthodontic treatment (e.g., braces, Invisalign)
- ☐ Jaw joint clicking, popping, or pain
- ☐ Gums that bleed during brushing or flossing
- ☐ Currently wear a denture or partial appliance

- [ ] Frequent dry mouth
- [ ] Clenching or grinding of teeth
- [ ] Loud snoring or diagnosed sleep apnea
- [ ] Dissatisfaction with tooth color, shape, or alignment
- [ ] None of the above

If any of the checked boxes need further explanation, please describe below

What medical conditions do you have?

Select Medical Conditions

Type or select medical condition

Medical conditions not listed

Please add any medical conditions you don't see in the list above.

What allergies do you have?

Select Allergies

Type or select allergy

Allergies not listed

Please add any allergies you don't see in the list above.

What medications are you taking?

Select Medications

Type or select medication

Medications not listed

Please add any medications you don't see in the list above.

Do you require premedication(such as antibiotics) before dental treatment? *

- Yes
- No

Preferred Pharmacy

Pharmacy Name *

Pharmacy Phone *

Pharmacy Fax

Pharmacy Address

Type in to search your address

Address Line 1 *

Address Line 2

City *

Zip

Consents

Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

Appointment Scheduling Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be rescheduled at least 48 hours in advance.

Our doctors & hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. There will be a fee of $50.00 assessed if we do not receive a call to make necessary appointment changes.

Thank you for being a valued patient and for your understanding and cooperation. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

☐ By checking this box, you attest to understanding and agreeing to the above Scheduling Policy. *

Consents & Signature

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I allow this practice to disclose my Protective Health information to the following individuals: (This information could include Name, Diagnosis, Test Results, Image

and Account Information)

Name

Relationship to Patient

Signature

By providing my signature below, I hereby consent to treatment as recommended by my provider. I attest that I have read, I understand and agree to the above Consents/Policies. This consent shall be considered in effect until rescinded or revoked. *

Draw

Sign here

Privacy Policy