DENT+URGENT

NEW PATIENT INFORMATION

❖ MARITAL STATUS (please circle): Single Married Divorced Widowed Other					
LAST		FIRST		MI	SEX M F
ADDRESS	UNIT	CITY		STATE	ZIP
PRIMARY EMAIL ADDRESS		DATE OF BIRTH	S.S.N.		
HOME PHONE	CELL		WORK		

EMERGENCY CONTACT PERSON	RELATIONSHIP	PHONE NUMBER

DO YOU REQUIRE ANTIBIOTICS PRIOR TO DENTAL APPOINTMENT? YES NO	
IF YES, WHAT FOR?	
PRESCRIBING DOCTOR	DOCTOR'S PHONE

* **LAST DENTAL CHECK-UP / CLEANING:** 6 Months Ago 7-12 Months Ago 13+ Months Ago

- ***(FOR FEMALE): ARE YOU CURRENTLY PREGNANT OR NURSING?** YES NO
- ***SMOKE OR USE ANY TOBACCO PRODUCTS?** **YES NO**
- ***HAVE YOU USED ANY RECREATIONAL DRUGS IN THE PAST 24 HOURS ?** YES NO
- ***DO YOU FLOSS YOUR TEETH DAILY?** YES NO
- ***DO YOUR GUMS BLEED WHEN FLOSSING?** YES NO
- ***HAVE YOU EVER BEEN TOLD THAT YOU HAVE PERIODONTAL DISEASE?** YES NO
- ***ARE YOU CURRENTLY HAVING ANY DENTAL PAIN OR DISCOMFORT?** YES NO
- ***ARE YOUR TEETH SENSITIVE TO HOT/ COLD/ PRESSURE OR SWEETS?** YES NO
- ***DO YOU HAVE ANY MOBILITY IN YOUR TEETH?** YES NO
- ***ARE YOU AWARE OF ANY OF THE FOLLOWING:**

  CLENCHING GRINDING SNORING DIFFICULTY BREATHING BAD BREATH NONE

- ***HOW DO YOU FEEL ABOUT HAVING DENTAL TREATMENT DONE?** FINE NERVOUS PHOBIA
- ***IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU LIKE TO CHANGE?**
  COLOR/SHADE SHAPE FUNCTION OTHER ________________________________

(X)SIGNATURE **DATE**

MEDICAL HISTORY

DO YOU HAVE A PERSONAL PHYSICIAN? YES NO

PHYSICIAN	PHONE NUMBER

DO YOU HAVE DENTAL INSURANCE? YES NO

*NAME OF PRIMARY INSURED (POLICY HOLDER)	*NAME OF EMPLOYER
NAME OF DENTAL INSURANCE DENTAL INSURANCE ID#	DENTAL CUSTOMER SERVICE PHONE#

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? YES NO

- ASPIRIN
- BARBITURATES
- CODEINE
- PENICILLIN
- EPINEPHRINE
- LATEX
- ERYTHROMACIN
- SULFA
- OTHER:

PLEASE CHECK ALL THAT APPLY (WITHIN 5 YEARS)

- ABNORMAL BLEEDING
- ANEMIA
- ARTHRITIS
- ARTIFICIAL JOINTS
- ARTIFICIAL VALVES BLOOD
- TRANSFUSION
- ASTHMA
- CANCER
- ALCOHOL ABUSE
- DIFFICULTY BREATHING
- DRUG ABUSE
- COLITIS
- CHICKEN POX
- EMPHYSEMA
- HIGH BLOOD PRESSURE
- CHEMOTHERAPY
- EPILEPSY
- HAY FEVER
- GLAUCOMA
- LOWER BLOOD PRESSURE
- FAINTING SPELLS
- FEVER BLISTERS
- HERPES
- HEART ATTACK
- HEADACHES / MIGRAINES
- HEART MURMUR
- HEART SURGERY
- HOSPITALIZED
- HEMOPHILIA
- LIVER DISEASE
- HEPATITIS
- HIV/AIDS
- LUPUS
- KIDNEY PROBLEMS
- STROKE
- MITRAL VALVE PROLAPSE
- PACEMAKER
- SEIZURES
- PERSISTENT COUGH
- RADIATION TREATMENT
- PSYCHIATRIC PROBLEMS
- SCARLET FEVER
- DIABETES
- RHEUMATIC FEVER
- CONGENITIAL HEART DEFECT
- OTHER:

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? YES NO

NAME OF MEDICATION	DOSAGE OF MEDICATION	WHAT ARE YOU TAKING THIS FOR?

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest of confidence and it is MY responsibility to inform the DENTURGENT of any changes in my medical status.

(X)

SIGNATURE **DATE**

OFFICE POLICIES/PROTOCOLS

__________**(INITIAL)** **NEW PATIENT FORMS**

It is our obligation as a dental provider to care for our patients in the most careful and precise way possible. It is **imperative that all patient forms are thoroughly completed and kept up to date**. We will update your information yearly unless there are changes in between time, and **patient is responsible to keep their file updated**.

FINANCIAL POLICY	COLLECTION PROCESS
It is our financial policy to collect fees at the time that service is provided. For your convenience, we accept cash, check and all major credit cards. Any unpaid balance is subject to review by a professional collection agency up to and including legal actions. __________**(INITIAL)**	Our office will attempt to contact you via phone, mail and/or email to resolve unpaid balances prior to your account being referred. If we are not able to obtain successful communication, you account will be referred to a third party for further assistance. __________**(INITIAL)**

__________**(INITIAL)** **INSURANCE HOLDERS**

It is the patient responsibility to keep insurance information up-to-date with the office at all times. Your benefits will be checked prior to your visit with our office. Any changes or updates to insurance information should be provided to us PRIOR to your dental appointment so we will have time to verify benefits and coverage. Our office is contracted with MOST major insurance plans. As a courtesy to our patients, we are happy to file claims with your insurance company for services performed. Please be sure to provide all dental and/or medical insurance information to our office prior to your appointment. It is also the patient responsibility to verify that your insurance information is updated with the office at all times. All co-pays and coinsurances are due at the time of service and any balance that is unpaid by the insurance will be billed to the patient accordingly. We will always attempt to get precise benefits from your insurance provider however there is **never a guarantee** of payment until they process the claim.

__________**(INITIAL)** **APPOINTMENT CONFIRMATIONS / RESCHEDULES/ CANCELLATIONS/ NO-SHOWS**

It is our policy to call, email and text appointment reminders to you a day or so prior to your scheduled visit. We have reserved a specific day and time to provide your dental care so it's very important that we are able to get confirmation of your intent to be at your appointment. We do understand that things happen in your daily schedule as well as our patient schedule so we have no problem working with you. We normally **ALLOW A 10 MINUTE WINDOW** after your scheduled appointment time for your arrival before we attempt to contact you. If you do feel that you will be late or will not be able to show for your scheduled appointment, please call our office as soon as possible.

CANCELLATIONS AND NO-SHOW APPOINTMENTS
****SAME DAY CANCELLATIONS WILL BE CHARGED AT $25**** ****NO-SHOW WILL BE CHARGED AT $50**** YOU ARE COMPLETELY RESPONSIBLE FOR THESE CHARGES IN FULL AMOUNT.

I, ____DO ACKNOWLEDGE THAT I HAVE REVIEWED OVER THE OFFICE POLICIES AND PROCEDURES LISTED ABOVE AND AGREE TO ADHERE TO THE OFFICE PROTOCOLS.

(X) ____

SIGNATURE **DATE**