Welcome Information

Cell Phone: (____) _____.

Name:_____ Work Phone: (____) _____.

Email:_____@_____ Home Phone: (____) _____.

How would you prefer to be contacted? email, text, cell phone (circle one or more)

Home Address:_____ City:_____ Zip Code:_____.

Social Security #:_____ Date of Birth:_____.

As a courtesy, would you like us to call for your prior records? Yes or No (circle one)

Prior Dentist:_____ Town & State: _____.

Whom may we thank for referring you to us?_____.

Who is responsible for any cost incurred? _____.

Dentistry at Suburban Square is dedicated to the best quality, service and comfort available. In return we expect payment upon date of service. If you are unable to meet your obligation to this practice, please inquire about payment plan options. I understand and agree that (regardless of my insurance status, marital status, or divorce status), I am ultimately responsible for the balance of my/the patient's account for all professional services rendered and any/all costs incurred as a result of not meeting my obligations. I authorize this office to use this signature and information as approval to submit insurance claims on my/the patient's behalf and to facilitate full remuneration. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or any information within this packet.

*Signature*_____ Date_____.

Parent Signature (if minor)

Help Us Help You

What can we do for you?

What is most important to you while you are in our care?

What type of care would you like to receive? (circle one or more)

Cosmetic care that improves your smile, overall appearance, and sense of confidence.
Proactive care that improves and maintains your overall oral health.
Maintenance care that treats issues only when absolutely necessary.
Emergency care that gets you out of pain.

What type of care would you like to invest in? (circle one or more)

Cost is not an issue: The best care possible.
Best value care: Quality care which may increase my short term costs while reducing my long term costs.
Least expense care: Reduce my immediate expense.

Dental Insurance Information (optional)

As a courtesy, we offer many different opportunities to help you get the best value and the most back from your insurance benefit, without sacrificing the quality of your care or your health. Many of our patients have dental insurance and use it to remunerate/supplement the cost of their care. We can complete and submit all your claims. We can wait upon your estimated insurance portion of your balance. And with our extensive knowledge of insurance reimbursement, we can follow-up and pursue the greatest possible return on your behalf. Please have our front desk copy your insurance card. If you are a full-time student we will also need a copy your student ID.

If you have insurance:

Name of Policy Holder: _____ Relationship to Patient: _____.

Policy Holder SS #: _____ Policy Holder Birth Date: _____.

Policy Holder Employer: _____ Insurance Company: _____.

Insurance Group #: _____.

Medical History

Your overall health and safety are of paramount importance to us. It is critical that we know all medical information no matter how non-pertinent you may feel it is. The information obtained is completely confidential. The interrelationship between your mouth and your entire body should not be underestimated. Please be honest and forthcoming in order to best avoid complications and risk to your oral well-being and your overall health.

Please list **ALL** medications that you are taking; prescription, over-the-counter/non-prescription, herbal remedies, and recreational drugs:

□ Fosamax (or like medication) currently or ever?

□ none

Please list **ALL** allergies or substances you have experienced any unusual reactions to including any medications:

Ibuprofen / Motrin /Advil	Acrylic	Local Anesthetics/Novocain
Antibiotics	Metals	Epinephrine/Adrenaline
Narcotics	Latex	Other:

□ none

Have you ever been hospitalized, when, and for what?

□ never

When was your last physicians visit, why were you there, and what was the outcome?

□ never

Do you have any history of heart disease or conditions (for yourself) including but not limited to; artificial heart valve(s), a history of infective endocarditis, any congenital (present form birth) heart conditions, a cardiac transplant that develops a problem in a heart value?

□ none

Have you ever been told you need to "pre-medicate" or take antibiotics prior to a dental/medical procedure? Yes or No (circle one)

Do you have any Hip/shoulder/knee or other implants? Yes or No (circle one) Year placed? _____.

Are there any other illnesses that you are currently or historically suffering from?

□ none

If you are female: Are you or could you be pregnant or nursing? Yes or No (circle one)

Are you currently taking birth control medication? Yes or No (circle one)

- please turn over and complete -

Have you experienced any of the following? (please circle)

CARDIOVASCULAR:

Angina Pectoris | Heart Attack/Failure | Heart Pace Maker | High/Low Blood Pressure | Chest Pain
Arrhythmias | artificial heart value(s) | Heart Surgery/Transplant | Stroke | Aneurysm
History of infective endocarditis | any Congential Heart Conditions | Cardiac Transplant that develops a problem in a heart value

HEMATOLOGIC:

Tendency to Bleed Longer than Normal | Anemia | Blood Transfusion | Bruise Easily | Clotting Disorder | Hemophilia
Hepatitis A (food Bourne) | Hepatitis B/C (Blood Bourne) | HIV positive/AIDS | Leukemia | Sickle Cell Disease

NEURAL & SENSORY:

Vision Problems | Glaucoma | Hearing Loss | Severe/Frequent Headaches
Fainting/Dizziness | Epilepsy, Seizures, or Convulsions | Psychiatric Care | Psychological Disorders
Alzheimer's Disease | Shingles | Earaches/Tinnitus

GASTROINTESTINAL:

Stomach or Intestinal Ulcers | Gastritis | Colitis | Persistent/Frequent Diarrhea | Acid Reflux/GERD
Liver Disorder/Disease | Yellow Jaundice | Cirrhosis | Irritable bowel

RESPIRATORY:

Hay Fever | Sinus Trouble | Rash/Hives | Asthma | Chronic Cough | Breathing Problems
Easily Winded | Emphysema | Lung Disease/Problems | Tuberculosis (TB) | Coughing up Blood

DERMAL MUCOCUTANEOUS MUSCULOSKELETAL:

Anaphylaxis | Arthritis/Gout | Artificial Joints or Implant of any type | Rheumatism | Cold Sores/Fever Blisters
Dark Mole(s) with recent change in appearance or irregular border | Jaw Joint Pain | Jaw Joint Popping/Clicking

ENDOCRINE:

Cortisone Medicine | Diabetes | Hypoglycemia | Parathyroid Disease | Thyroid Disease

URINARY/SEXUALLY TRANSMITTED DISEASE:

Kidney Problems | Renal Dialysis | Genital Herpes | Herpes | Venereal Disease

OTHER CONDITIONS:

Alcohol Addiction/Dependency | Tobacco Use | Cancer | Tonsillitis | Recent Weight Loss
Drug Addiction/Dependency | Chemotherapy | Dry Mouth | Scarlet Fever | Radiation Treatment
Phen-fen or Redux use | Excessive Thirst | Spina Bifida | Swelling of limbs | Tumors or Growths
Fosamax (or like drug) prior use | Other Disease or Problem Not Listed

□ none

To the best of my knowledge, the medical history questions have been accurately answered. I acknowledge understanding that providing incorrect or misleading information can be dangerous to my (or patient's) health. It is my responsibility to inform the dentist of any changes in medical status and/or medications.

Parent Signature (if minor)

Signature_____ Date_____.

Team Member Initials verifying form complete _____

Team Member Initials entering computer info _____ BP:_____/_____ left/right arm ASA: I II III IV

Image Release

We are very proud of the quality of care we provide, and we love to tell and show our current patients and potential patients the amazing work we do for you. To do this we ask for you help. With consent we would use images to inform and educate other patients in our office, on our website and/or marketing materials. However, we understand and respect your privacy. You are under no obligation to consent to such release, nor will such impact your treatment or any fee associated with such. Please consider a level of release that satisfies everyone's preferences.

□ I give permission to use images of my face (and voice if video) and teeth.

□ I only give permission to use images of my teeth and mouth/lips.

□ I do not give permission.

I understand that I may revoke this authorization by written notice. However, revocation only applies to new uses of any released images and can not recall prior uses. Further, I understand that there is no compensation for use of images.

Signature_____ Date_____.

Financial Options

Initials**_____** Parent Initials (if minor)

We pride ourselves on providing the best dentistry has to offer with the finest quality of care, service and comfort available. We firmly believe that by treating you the right way you can achieve great oral health for the long term, and enjoy your visits with us. To achieve our mutual goals, full payment is expected and due at time of service. We offer several programs and payment options listed below that we invite you to take advantage of. Finances can always be a varied and sometimes sensitive topic. We treat persons with a wide range of preferences. By letting us know your concerns we can customize to your wishes. It is best to be up front with us.

Generous Discounts: (Benefits are subject to change, some restrictions apply)
10% Discount for services upon full payment with CASH/CHECK at start of treatment. "So bring your check with you."
12% Discount for services with full payment with CASH/CHECK at start of treatment if 65 years or older and between 10am - 3pm.
Credit cards are accepted without discount. Charge backs are not an available option under any circumstance.

No Interest Payment Plans: Care Credit &/ other third party's offer a medical line of credit that can be used here. Use of this can extend your payments up to 6 months with no interest or fees. In addition, there are extended payment plans with reasonable interest fees available. It only takes 5 minutes to apply through our front desk or online.

Dental Dollar Gift Certificates: Gift certificates you can give to your loved ones & friends that want quality dental care.

Affordable Dental Plan: As low as $199 per year includes two free cleanings, two exams & yearly 'x-Rays' with reduced treatment fees up to 50%. Conditions will reduce your flexibility and service without sacrificing the high quality of care. Details can be provided.

Payment: Certain instances require anticipated full payment prior to treatment. The appointment may be rescheduled if needed. Any & all payments not utilized will be credited to your account, but not refunded.

Insurance Options

Initials**_____** Parent Initials (if minor)

Insurance is a great supplement to the quality care you deserve. We welcome and accept almost all insurance (Sorry no HMO or DMO). Our service includes our ability to maximize your insurance. Upon receipt of your correct insurance information, we can contact your insurance company and research what coverage you have and how it can be maximized to help you. We can fill out & submit all claims on your behalf, unless you request otherwise. We will make every effort to estimate your insurance coverage as accurately as possible. The following are your options:

1) Pay the entire balance of treatment at time of service and receive a 10% discount (with cash or check) and your insurance reimbursement will be sent directly to you. ***OR***

2) Have us wait for your insurance payment, only pay the estimated remaining balance at time of treatment. Upon receipt of the insurance payment we will refund you any overpayment or bill you any remaining balance (if any). ***OR***

3) On occasion, a small number of insurance plans will only send payment directly to you. If this is your situation, you have the same options as above; pay the entire balance and receive a 10% discount OR pay the estimated remaining balance at time of treatment and have us wait for your insurance payment from you (upon your receipt of such).

Cancelation and No Show Information

Initials**____** Parent Initials (if minor)

We do our very best to value and respect your time. We require the same courtesy in return.

Our View: An appointment made is a commitment between you and us. It is a reserving of time in our schedule for you and your dental needs. That reservation limits access for needed and wanted care for other people. It also enables this office to appropriately remunerate all the talented people who are helping you with your dental concerns. While we understand the many priorities we all face in today's hectic world, we count on you to honor your obligation of time with us.

Our expectations and your obligation: An appointment made will be confirmed two to four business days in advance.
An appointment cancelled or rescheduled within 2 business days or less, a confirmed appointment, or an appointment not attended without notice, is considered a cancellation or no-show.
Although we prefer not to, we reserve the right to charge for such. These charges can range from the anticipated fees for the procedure(s) that would have been preformed to the average values of our used treatment times. We do everything to avoid this unpleasantry; we ask you do the same.

I have reviewed the above information and had any & all questions answered to my satisfaction. All changes to these policies will be posted in our waiting room and will apply.

Initials**_____** Parent Initials (if minor) Date**_____.**

If interested, we are happy to offer a copy of this page to take home.