# Patient Intake Form

Date_____ Name_____
*First MI Last*

Address_____
*Street City St Zip*

Main Phone# (___)_____ Gender: Male ☐ Female ☐ Status: Married ☐ Single ☐

Birth Date: _____/_____/_____ Soc. Sec. #_____ Preferred Name:_____
*(if different from above)*

Email Address:_____*(used for patient communication/business only)*

Employer Information: ☐ Retired ☐ Employed by: _____

_____ Work Phone#__(_____)_____
*Employer's Address City Zip*

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**Insurance Information**: Do you have Dental Insurance? Yes No
If "YES", please provide your insurance card for a photocopy.

If you do not have a card, Please fill in as much information below as possible to assist us in learning of any available benefits you may have.

☐ I am the subscriber ☐ I am the dependent (Subscriber's Name)_____
*First Last*

Subscriber's Soc Sec or ID #_____ Subscriber's Birth Date ____/____/____

Insurance Name _____ Group Name _____

Group # _____ Insurance Benefit Phone Number _____

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**FINANCIAL AGREEMENT**

I understand and agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. Our office accepts cash, personal checks, MasterCard, Visa and Discover. Our office also offers outside financing upon request and approval. Please ask for further details. In the event that payments are not received by agreed upon dates, I understand that any unpaid balance will accrue interest at 1.5% per month. If the entire balance with accrued interest is not paid within 90 days, reasonable collection fees of 40% will be added to the account and turned over to collections.

**INSURANCE**

As a courtesy to our insured patients, we will gladly file your dental claims for services rendered on your behalf, however we do not guarantee payment of benefits. Please understand that we are only given an estimate for your dental care therefore we can only pass the estimate on to you, the patient. After your insurance pays their portion, there may still be an amount due. This amount will be your responsibility and will be sent to you in the form of a statement. Please understand that we will do our best to get your insurance to pay for all work performed by our office. However, most insurance plans only pay for a portion of dental services. Please understand that if after 60 days, there has been no payment made, it is your responsibility to pay your account in full and to follow up with your insurance to retain payment. If your insurance coverage does not cover the estimated amount, you will be responsible for payment in full. Deductibles, co-insurance, non-covered services (including pre-existing conditions), and services denied due to insurance eligibility is your responsibility. By signing below, you authorize your insurance company(s) to pay Natural Dentures & Natural Smiles all Insurance benefits for dental services rendered to you or members of your family. You authorize the use of this signature on all insurance claims.

**ADDITIONAL CHARGES**

*I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel and do not show up a charge will be assessed for time reserved and future appointments will need to be prepaid.
*I understand that a $25 fee will be charged to transfer records electronically (Over 25 MB).
*I understand that a $25 fee will be charged for hard copies of your record.

**Interning/Externing**

I give permission for interns/externs to work directly with me and on my treatment as they are being overseen by a qualified and approved interning/externing supervisor. If I have any concerns or wish not to be seen by one, I will inform the supervisor on site of that decision.

_____ _____
Patient (authorized) Signature Date

# Patient Health Record

Do you currently use tobacco products? Yes No
Do you wear dentures/partials now? Yes No if "yes", how old is the most current one? _____
Do you have a personal Dentist? Yes No Dentist's Name_____
Do you have a personal Physician? Yes No Physician's Name _____
Have you been instructed by a physician to have antibiotics prior to any dental appointment? Yes No
Are you currently on any blood thinning medication? Yes No
Are you currently taking, or have you ever taken, Bisphosphonates? Yes No
Do you have problems with a dry mouth? Yes No
Rate your overall happiness with your current smile (Scale: 1 worst – 10 best) _____
What would you like your smile to be (Scale: 1 worst – 10 best) _____

Please mark below if you have or have had any of the following:

_____ Anemia
_____ Medication Allergies:
_____ Aspirin
_____ Codeine
_____ Erythromycin
_____ Latex
_____ Penicillin
_____ Tetracycline
_____ Other _____
_____ Artificial Joints
_____ Arthritis _____
_____ Asthma
_____ Alzheimer's / Dementia / Memory Loss
_____ Blood Pressure ~ High
_____ Blood Pressure ~ Low
_____ Blood disease
_____ Cold Sores
_____ Congenital Heart Defect
_____ Diabetes

_____ Difficulty Breathing
_____ Drug/Alcohol Abuse
_____ Dry Mouth
_____ Emphysema
_____ Epilepsy / Seizures / Fainting
_____ Excessive Bleeding
_____ Fibromyalgia
_____ Heart Murmur
_____ Hemophilia
_____ Herpes
_____ Heart Attack
_____ Hepatitis A B C
_____ HIV +/ Aids
_____ Kidney Disease
_____ Nervous Problems
_____ Headaches ~ Chronic
_____ Cough Persistent
_____ Cancer
_____ Osteoporosis

_____ Rheumatic Fever
_____ Shortness of Breath
_____ Thyroid Problems
_____ TMJ Problems
_____ Tuberculosis
_____ Tumors
_____ Ulcers
_____ Radiation Treatment
_____ Parkinson's Disease
_____ Pacemaker
_____ Surgery of Mouth
_____ Stroke
_____ Stomach Problems
_____ Skin Rash
_____ Sinus Problems
_____ Circulatory Problems
_____ Chemotherapy
_____ Allergies: _____
_____ Other _____

Do you have any recent hospitalizations?_____

Please list any current medications you are taking: _____

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**Referral Information**: Whom may we thank for referring you to our practice?

☐ Another Patient ☐ Dental Office ☐ Phone Book ☐ TV ☐ Internet
☐ Newspaper ☐ Other _____

***Name of Person*** *or business that referred you to our practice*?_____

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Patient (authorized) Signature Date