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# (____)________________

Emergency Contact:________________________________ Emergency Contact Phone# (_____)______________________

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 _______________________

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.
*I understand that a $35 fee will be charged for NSF checks.

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*?_______________________________

____
Patient Printed Name

____ ______________________________
Patient (authorized) Signature Date