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 a Spouse/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 _____

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*?_____

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

Financial Agreement & Insurance Information

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. If 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.

_____
Patient Printed Name

_____ _____
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 allergies to any of the following:

	Aspirin		Penicillin
	Codeine		Tetracycline
	Erythromycin		Other:
	Latex		

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

	Anemia		Emphysema		Rheumatic Fever
	Artificial Joints		Epilepsy / Seizures / Fainting		Shortness of Breath
	Arthritis		Excessive Bleeding		Sinus Problems
	Asthma		Fibromyalgia		Skin Rash
	Alzheimer's / Dementia / Memory Loss		Headaches ~ Chronic		Stomach Problems
	Blood Pressure ~ High		Heart Attack		Stroke
	Blood Pressure ~ Low		Heart Murmur		Surgery of Mouth
	Blood disease		Hemophilia		Thyroid Problems
	Cancer		Hepatitis A		TMJ Problems
	Chemotherapy		Hepatitis B		Tuberculosis
	Circulatory Problems		Hepatitis C		Tumors
	Cold Sores		Herpes		Ulcers
	Congenital Heart Defect		HIV +/ Aids		
	Cough Persistent		Kidney Disease		Allergies:
	Diabetes		Nervous Problems		
	Difficulty Breathing		Osteoporosis		
	Drug/Alcohol Abuse		Parkinson's Disease		Other:
	Dry Mouth		Radiation Treatment		

Do you have any recent hospitalizations?_____

Please list any current medications you are taking: _____

_____

_____
Patient Printed Name

_____ _____
Patient (authorized) Signature Date