

Patient Information

Name _____

Address _____

City _____

Phone _____

Email _____

Birth date _____

Social Security _____

Married Single Widowed

Occupation _____

Employer _____

How did you hear about us? _____

Reason for today's visit _____

Dental Insurance

Primary Dental Subscriber _____

Subscriber ID/SS# _____

Insurance Company _____

Group # _____

Secondary Coverage _____

Emergency Contact _____

Dental History

Date of last dental visit _____

Date of last dental x-ray _____

How often do you brush/floss? _____

Bad breathe Yes No

Fingernail biting Yes No

Bleeding Gums Yes No

Food Collection between teeth Yes No

Blisters on lips or mouth Yes No

Grinding teeth Yes No

Burning sensation on lips or mouth Yes No

Gums swollen or tender Yes No

Chew on one side of the mouth Yes No

Loose teeth or broken fillings Yes No

Cigarette, pipe, or cigar smoking Yes No

Mouth Breathing Yes No

Clicking or Popping jaw Yes No

Mouth Pain Yes No

Dry Mouth Yes No

Orthodontic Treatment Yes No

Pain around ear Yes No

Periodontal treatment Yes No

Sensitivity to hot Yes No

Sensitivity to cold Yes No

Sensitivity to sweets Yes No

Sensitivity to biting Yes No

Sores or growths in your mouth Yes No

Health History

Physicians name _____ Date of last visit _____

Have you ever taken any of the drugs collectively known as Phen-Fen? _____

AIDS/HIV Yes No

Congenital heart lesions Yes No

Anemia Yes No

Cortisone treatments Yes No

Arthritis Yes No

Cough, persistent or bloody Yes No

Artificial Heart Valve Yes No

Diabetes Yes No

Artificial joints Yes No

Emphysema ___Yes ___No Asthma ___Yes ___No Epilepsy ___Yes ___No
 Back problems ___Yes ___No Fainting or dizziness ___Yes ___No Bleeding abnormally with extractions or surgery ___Yes ___No
 Glaucoma ___Yes ___No Blood disease ___Yes ___No Headaches ___Yes ___No
 Cancer ___Yes ___No Heart murmur ___Yes ___No Chemical dependency ___Yes ___No
 Heart Problems ___Yes ___No Chemotherapy Hepatitis type _____ Yes ___No Circulatory Problems ___Yes ___No
 Herpes ___Yes ___No High Blood Pressure ___Yes ___No Jaundice respiratory disease ___Yes ___No
 Jaw pain ___Yes ___No Rheumatic or scarlet fever ___Yes ___No Kidney disease ___Yes ___No
 Shortness of breath ___Yes ___No Liver disease sinus trouble ___Yes ___No Low blood pressure ___Yes ___No
 Skin rash ___Yes ___No Mitral valve prolapse ___Yes ___No Special diet ___Yes ___No
 Nervous problems ___Yes ___No Stroke ___Yes ___No Pacemaker ___Yes ___No
 Swollen feet or ankles ___Yes ___No Psychiatric problems ___Yes ___No Swollen neck glands ___Yes ___No
 Radiation treatment ___Yes ___No Thyroid problems ___Yes ___No Tonsillitis ___Yes ___No
 Tuberculosis ___Yes ___No Tumor or growth on head or neck ___Yes ___No Ulcer ___Yes ___No
 Venereal disease ___Yes ___No Weight loss unexplained ___Yes ___No Do you wear contact lenses ___Yes ___No
 Are you pregnant? ___Yes ___No Due date _____ Are you nursing? ___Yes ___No

Medications: _____ Allergies: _____

Circle if applicable: Latex Aspirin Iodine Penicillin Local Anesthetic Sulfa

Financial Responsibility & Insurance

I assume financial responsibility for all dental treatment and understand that all charges are payable at the time of treatment. Your treatment plan will include a breakdown of all applicable fees, please ask a member of our team to review your payment options. We will electronically submit all insurance claims for you and will attempt to help you receive full insurance benefits. You are personally responsible for your account and knowledge of your dental insurance plan. Dental insurance is a contract between you and your employer or independent party. Because insurance policies vary, we can only estimate your coverage in good faith and cannot guarantee coverage for your specific insurance plan. I request and authorize my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and I therefore am ultimately responsible for payment of services rendered on my behalf or my dependents. I am responsible for furnishing all necessary insurance documents or insurance changes to Image Dental in order for them to process my insurance claim quickly and efficiently. If I do not furnish the necessary insurance documents or inform Image Dental of insurance changes, I am fully responsible for any unpaid or rejected balances. As a service to our patients we bill insurance companies and allow them 45 days to render payment, after 60 days of nonpayment you are responsible for the balance or contacting the insurance in order to settle the balance with our office.

Initials _____

Appointments

Your scheduled appointment time has been reserved specifically for you. We request 24-hours notice if you need to cancel your appointment. We are aware that unforeseen events sometimes require missing an appointment. After missing your second appointment without notifying us 24 hours in advance, you are subject to being charged an additional fee.

Initials _____

Authorization and Release

To the best of my knowledge the information I have given on this form is correct, and I understand that providing incorrect information can be dangerous to my health and dental treatment. It is my responsibility to inform the dental office of any changes in my medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or exam rendered to me or my dependent during the period of such dental care to third party payors and / or their health practitioners. I have received a copy of this office's Notice of Privacy Practices. I consent to their use and disclosure of my Protected Health Information to carry out treatment, payment activities and healthcare operations. I also acknowledge that I have received the dental material fact sheet.

Initials _____

Signature: _____ Date : _____