Adult Patient Information

Date_____

Patient's name_____

Residence/Mailing address_____

How long at this address_____ Home phone_____ Work phone_____ Cell phone_____

Previous Address (if less than 3 years)_____

Birthdate_____ Social Security #_____Email Address_____

Marital Status: Single__ Married___ Widowed___ Separated____ Divorced__

Employer _____Occupation_____ No. yrs employed_____

Spouse's Name_____ Relationship to patient_____

Employer_____ Occupation_____ No. yrs employed_____

Social Security#_____ Birthdate_____ Work Phone_____

Whom may we thank for referring you to our office?_____

Dental Information

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____ Member id No._____

Insurance Co. Address_____ Phone No._____

Do you have dual coverage?_____ Yes__ No__ If Yes:_____

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No ._____Member id No._____

Insurance Co. Address_____ Phone No._____

Emergency Information

Name of nearest relative not living with you_____

Complete address_____ Phone Number_____

I understand that If I choose to apply for Financing with CareCredit, credit bureau reports may be obtained.

Signature_____

Updates (Date & Initial)_____

A B C

PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date_____

Patient's name_____
Last First Middle

Address _____
Street City Zip

Nickname_____ Birthdate_____ Social Security # _____

School_____ Sports/Hobbies_____

Parent or guardian name_____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Name_____
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

How long at this address?_____ Home phone_____ Work phone _____

Cell/other phone_____ Email address _____

Previous Address (If less than 3 years) _____

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. years employed _____

Spouse's Name_____ Relationship to Patient _____

Employer_____ Occupation_____ No. years employed _____

Social Security # _____ Birthdate _____Work Phone_____

DENTAL INSURANCE INFORMATION

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No._____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No._____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone _____

I understand that, where appropriate, credit bureau reports may be obtained.

Parent Signature _____

Updates (date & initial) _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____
Please circle Yes or No (If Yes, please fill in details)

Yes No Is the patient taking any medication? _____
Yes No Is the patient allergic to any medication? _____
Yes No History of a major illness? _____
Yes No Has the patient had any operations? _____
Yes No Ever been involved in a serious accident? _____
Yes No Have seen a physician in the last 12 months? Why? _____
Female Patients only:
Yes No Has menstruation started? _____
Yes No Is the patient pregnant? _____

Circle any of the medical conditions below that the patient has had or currently has.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

DENTAL HISTORY

General Dentist _____ Date of last visit _____
What concerns you most about your teeth? _____

Yes No Is the patient presently in any dental pain? _____
Yes No Ever experienced any unfavorable reaction to dentistry? _____
Yes No Has the patient ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Is any part of your mouth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where? _____
Yes No Do gums bleed when brushing? _____
Yes No Any type of thumb or tongue habit? _____
Yes No Is the patient a mouth breather? _____
Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning? _____
Yes No Experience jaw clicking or popping? _____
Yes No Aware of clenching or grinding teeth during the day? _____
Yes No Experience "tension" headaches? _____
Yes No Has the patient ever experienced chronic ringing in the ears? _____
Yes No Does the patient need extra help with instructions? _____
Yes No Is the patient sensitive or self-conscious about his/her teeth? _____
Yes No Height of parents? Mom_____ Dad_____
Yes No Are you aware that some appointments will be during school hours? _____

ACKNOWLEDGEMENT

I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. _____ to perform a complete dental evaluation.

Signature: _____ Date: _____

ARENA DENTAL GROUP

WE APPRECIATE THE TRUST YOU HAVE PLACED IN US!

Policy & Financial Agreement

Dr. Candace Thomas and staff are pleased to welcome you to our practice. We look forward to providing you and your family with quality care rendered with the "latest and greatest" dentistry has to offer.

Payment is expected upon rendering services. All co-pays, deductibles, etc. must be made on the date of service.

We offer Care Credit, a "Dental Charge Card" that allows small monthly payments with extended plans for up to 18 months, no interest, based on your credit.

We gladly accept Cash, All Major Credit Cards-American Express, Discover, MasterCard, Visa and Care Credit.

BROKEN APPOINTMENTS

We require a 24 hour notice for all broken appointments otherwise there is a $25.00 broken appointment fee per 30 minutes due at the time of your next appointment.

IMPORTANT INSURANCE INSTRUCTIONS

We will file your insurance claim(s) as a courtesy to you and your family. Professional services are rendered and charged to you, not the insurance company. After 60-days, the account balance is your responsibility.

We do not determine the amount of coverage you will receive; your insurance carrier determines this. Any questions regarding coverage, deductibles, and limitations should be directed to your current carrier.

At time of service, we will contact your insurance carrier and get an "estimate of payment" for services rendered based on your coverage percentage rate for various dental procedures. The "estimated" portion your insurance does not cover is requested in full at time of service. After your insurance carrier makes payment, you will receive a statement of your account and bill, if there is a difference in the procedure charge and allowed amount by carrier .

All account balances must be paid within 10 days, after receipt of statement. Please be advised that if payment is not made on time, all outstanding amounts shall be deemed to be due immediately and payable without further notice. Failure to pay account may result in INTEREST, COLLECTIONS, AND/OR ATTORNEY FEES being added to the outstanding balance. These charges will be the patient or parent/guardian's responsibility.

I have read and reviewed the outlined statements above:

Signature _____ Date _____

Patient Name_____

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name_____ **Birth Date** _____

Signature _____ **Date** _____