

**Dental Passion LLC**

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# Welcome

*We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.*

***Patient Information***Name: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_  
Last Name First Name Initial

Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex:  M  F Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Single  Married  Widowed  Separated  Divorced 

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

In case of emergency who should be notified? \_\_\_\_\_

***Primary Insurance***

Person Responsible for Account:

\_\_\_\_\_  
Last Name First Name Initial

Relation To Patient: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

Address (If different from patient's) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Person Responsible Employed By: \_\_\_\_\_ Occupation: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Subscriber/Member ID#: \_\_\_\_\_ Group #: \_\_\_\_\_ Contract #: \_\_\_\_\_

***Additional Insurance***Is Patient covered by additional Insurance?  Yes  No

Subscriber Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address (If different from patient's) \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Subscriber/Member ID#: \_\_\_\_\_ Group #: \_\_\_\_\_ Contract #: \_\_\_\_\_

Subscriber Employed by: \_\_\_\_\_

## Dental History

Reason for Today's Visit: \_\_\_\_\_ Date of Last Dental Care: \_\_\_\_\_

Former Dentist: \_\_\_\_\_ Date of Last Dental X-Rays: \_\_\_\_\_

Address: \_\_\_\_\_

Check (✓) if you have had problems with any of the following:

<input type="checkbox"/> Bad Breath	<input type="checkbox"/> Grinding Teeth	<input type="checkbox"/> Sensitivity to Hot
<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Loose Teeth or Broken Fillings	<input type="checkbox"/> Sensitivity to Sweets
<input type="checkbox"/> Clicking or Popping Jaw	<input type="checkbox"/> Periodontal Treatment	<input type="checkbox"/> Sensitivity when Biting
<input type="checkbox"/> Food Collection Between Teeth	<input type="checkbox"/> Sensitivity to Cold	<input type="checkbox"/> Sores or Growths in your Mouth

How often do you floss? \_\_\_\_\_ How often do you Brush? \_\_\_\_\_

## Medical History

Physician's Name: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Have you had any serious illnesses or operations? \_\_\_\_\_ If yes, describe: \_\_\_\_\_

Have you ever had any complications following dental treatment? \_\_\_\_\_ If yes, describe: \_\_\_\_\_

Do you have any health problems that need further clarification? \_\_\_\_\_ If yes, describe: \_\_\_\_\_

(Women) Are you currently pregnant? \_\_\_\_\_ Nursing? \_\_\_\_\_ Taking Birth Control Pills? \_\_\_\_\_

Check (✓) if you have or have had any of the following:

<input type="checkbox"/> Anemia	<input type="checkbox"/> Cortisone Treatments	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Arthritis, Rheumatism	<input type="checkbox"/> Cough, Persistent	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/> Cough Up Blood	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Skin Problems/Disease
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Swelling of Feet or Ankles
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Fainting	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Tobacco habit
<input type="checkbox"/> Cancer	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Headaches	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Respiratory Disease	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Venereal Disease

### MEDICATIONS

List medications you are currently taking:

\_\_\_\_\_

\_\_\_\_\_

### ALLERGIES

\_\_\_\_\_

\_\_\_\_\_

To the best of my knowledge, all the preceding answers and information provided are true and correct. If ever have any change to my health, I will inform my doctors at the next appointment without fail.

X \_\_\_\_\_ Date \_\_\_\_\_

## Authorization

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charge whether or not paid by insurance.

X \_\_\_\_\_ Date \_\_\_\_\_

## DENTAL PASSION LLC FINANCIAL AGREEMENT

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

**General:** Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

**MISSED APPOINTMENTS:** Unless we receive notice of cancellation 48 hours in advance, you will be charged \$50.00. Please help us service you better by keeping scheduled appointments.

**INSURANCE:** Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf. Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

**PAYMENT:** FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

Please indicate below the form of payment you wish to choose.

Cash or check

Visa, MasterCard, Discover

If you qualify, a monthly payment plan is available for your convenience.

**If payment is delinquent, the patient will be responsible for payment of collection.**

**I have read, understand and agree to the terms and conditions of this Financial Agreement.**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_