Patient Information

Today's Date: _____

First Name: _____ MI: ____ Last: _____ Preferred: _____ Title: ____

SSN: _____ Birth Date: _____ Gender: _____

☐ Married ☐ Single ☐ Separated ☐ Widowed ☐ Child ☐ Other _____

Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Emergency Contact: _____ Phone: _____ Relation to patient: _____

How did you hear about our office: _____

Patient Health & Dental History

ADHD	Y – N	Dizziness	Y – N	Kidney Disease	Y – N	Resp. Problem/Disorders	Y – N
Anemia	Y – N	Excessive Bleeding	Y – N	Latex Sensitivity	Y – N	Rheumatism	Y – N
Arthritis	Y – N	Epilepsy	Y – N	Liver Disease	Y – N	Seizures/Fainting Spells	Y – N
Artificial Joints	Y – N	Glaucoma	Y – N	Mitro Valve Pro	Y – N	Sinus Problems	Y – N
Asthma	Y – N	Gout	Y – N	Mental Disorders	Y – N	Stomach Problem/Ulcers	Y – N
Blood Disease	Y – N	Head Injuries	Y – N	Nervous Disorders	Y – N	Stroke	Y – N
Blood Pressure	(H) Y – N	Hearing Impaired	Y – N	Pacemaker	Y – N	Thyroid Disease	Y – N
Blood Pressure	(L) Y – N	Heart Disease	Y – N	PREMED	Y – N	Tuberculosis	Y – N
Cancer	Y – N	Heart Murmur	Y – N	Radiation Treatment	Y – N	Tumors or Growths	Y – N
Depression	Y – N	Hepatitis A/B/C	Y – N	High Cholesterol	Y – N	Been Hospitalized	Y – N
Diabetes 1 / 2	Y – N	HIV+ / AIDS	Y – N	Rheumatic Fever	Y – N	Smoke or Chew Tobacco	Y – N
Drink Alcohol	Y – N	Had Heart Surgery	Y – N	Under Care of a MD	Y – N	Pregnant	Y – N
Jaw Joint Pain (TMJ)	Y – N	Clench or Grind Teeth	Y – N	Difficulty Chewing	Y – N	Dental Anxiety	Y – N

Sensitivity to hot, cold, biting sweets or avoid brushing any part of your mouth? Yes or No

What is your estimate of your general health? Excellent / Good / Fair / Poor

Medical Questions

List any medications you are taking including nonprescription drugs:

_____

_____

_____

_____

Do you have any disease or problem you think we should know about?

_____

_____

_____

_____

Are you allergic to any medications? Y / N If yes, please list below:

_____

_____

Do you have any dental issues or questions?

_____

_____

I certify that I have read and understand the questions above. I understand that if I have a change in medical history that I will need to notify the office of any changes.

Adult / Guardian: The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropiate by the doctor to make a thorough diagnosis of the patient's dental needs. I authorize Dr. Hinder to perform all recommended treatment mutually agreed upon by me.

X: _____ / _____ / _____

Patient or Guardian Signature | Date | Relation to Patient

Financial Information

Today's Date: _____

Patient - First Name: _____ MI: _____ Last: _____ Preferred: _____

Responsible Party:

First Name: _____ MI: _____ Last: _____ Birth Date: _____

Address: _____ SSN: _____

City: _____ State: _____ Zip: _____ Email: _____

Insurance Information:

Primary Dental Insurance Company Name: _____ ID Number: _____ Group Number: _____

Address: _____ Insurance Phone Number: _____

Name of Insured_____ Employer: _____ Relationship to patient: _____

Secondary Dental Insurance Company Name: _____ ID Number: _____ Group Number: _____

Address: _____ Insurance Phone Number: _____

Name of Insured_____ Employer: _____ Relationship to patient: _____

Consent for Services:

Upon acceptance of treatment in this office, the patient/guardian assumes financial responsibility for payment of fees. Treatment is to be paid in full when services are rendered. Any balances over 90 days will be sent to a professional credit reporting/collection agency. You will be responsible to pay all fees of collections including an additional 40% of the balance. Any personal check that is returned unpaid will incur $35 NSF fee to absorb bank charges to our office.

For our patients with dental benefits: I authorize my insurance company to pay the dentist all insurance benefits rendered. I authorize the use of this electronic signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits.

We will assist you in maximizing your insurance benefits by filing claims on your behalf. Please be aware that your coverage depends solely on what your employer wishes to provide to employees. We do not base our treatment needs on what the insurance company will cover but rather what the best treatment is for you. Please remember all estimates that are provided are the best estimates we can provide based on the information your dental plan provides to us. Any difference in payment from your insurance and your account balance is the patient's responsibility. It is suggested for patient's to read their dental insurance policy to be fully aware of limitations on your benefits and coverage provided.

Appointments: Please understand that we reserve chair time exclusively for you when an appointment is made with us. In an effort to continually provide quality services, we ask that you keep your reserved appointment as it is scheduled. Kindly give a minimum of 1 business day notice if you need to change your appointment. Our time is valuable and so is yours. We will always do our best to be conscious of your time and complete your treatment efficiently. A broken appointment fee will be charged if a courtesy 1 business day is not given. The broken appointment fee can vary from $35-$100 depending on the treatment scheduled and the length of the time reserved. The office also reserves the right to deny any further treatment if a pattern of broken appointments and late cancelations are observed.

I acknowledge having received a copy of the Practice's Notice of Privacy Practices. I agree that a photocopy of authorization is valid as the original.

Please keep us informed of any changes to your health, or personal information so that we may serve you in the best possible manner.

X: _____ / _____ / _____

Patient or Guardian Signature | Date | Relation to Patient