Patient Information

Date_____ ☐Male ☐Female ☐Married ☐Single ☐Divorced ☐ Student ☐Child

Last Name_____ First Name_____ Middle_____

Date of Birth_____ Social Security Number_____

Address _____ City _____ State _____ Zip _____

E-Mail _____ Home #_____

Work #_____ Cell # _____

Employer _____ Phone # _____

If patient is a minor, give parents or guardian's name_____

Name of nearest relative not living with you_____

Complete Address_____ Phone # _____

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

☐Mailing to Home (List Publication) _____ ☐Location ☐Yellow Pages ☐Other_____

Responsible Party Information

Last Name_____ First Name_____ Middle_____

Date of Birth _____Social Security #_____ Relationship to Patient_____

Address _____ City _____ State _____ Zip _____

Home #_____ Work #_____ Cell # _____

Previous Address (if less than 3 yrs.)_____

Employer_____ Occupation _____ No. Years Employed _____

Address_____ Phone # _____

Spouse Information

Last Name_____ First Name_____ Middle_____

Date of Birth _____Social Security #_____ Relationship to Patient_____

Address _____ City _____ State _____ Zip _____

Home #_____ Work #_____ Cell # _____

Employer_____ Occupation _____ No. Years Employed _____

Address_____ Phone # _____

Dental Insurance Information

Primary Dental Insurance	Secondary Dental Insurance
Insured's Name_____	Insured's Name_____
Insured's Date of Birth_____	Insured's Date of Birth_____
Insured's Phone #_____	Insured's Phone #_____
Insured's Social Security #_____	Insured's Social Security #_____
Insurance Company _____	Insurance Company _____
Company Address _____	Company Address _____
_____	_____
Insurance Company Phone # _____	Insurance Company Phone # _____
Insured's Employer _____	Insured's Employer _____

Dental Information

Do your gums bleed when you brush? ☐ Yes ☐No

Are your teeth sensitive to heat or cold? ☐ Yes ☐No

Are your teeth sensitive to Pressure? ☐ Yes ☐No

Do you have a fear of the dentist? ☐ Yes ☐No

Do you grind or clench your teeth? ☐ Yes ☐No

Have you had your teeth bleached before? ☐ Yes ☐No

How do you feel about the appearance of your teeth? Do you: ☐Love them ☐Accept them ☐Want to change them

How do you feel about the appearance of your smile? Do you: ☐Love it ☐Accept it ☐Want to change it

Date of Last Examination _____ What was done at that time?_____

Are you interested in using Nitrous Oxide (Laughing Gas) ..... ☐Yes ☐No

Medical History Information

Patient Name _____

1. Describe your current dental problem(s)?_____

_____

2. Are you having pain or discomfort at this time? ☐Yes ☐No
3. Have you been a patient in the hospital during the past two years? ☐Yes ☐No
4. Have you been under the care of a medical doctor during the past two years? ☐Yes ☐No

   Physician's Name_____ Phone Number _____

   Address_____
5. Have you taken any medication or drugs in the past two years? ☐Yes ☐No
6. **Are you now taking any medications or drugs? (includes medication for pain, recreational drugs, and hormones)** ☐Yes ☐No

   If yes, please list:_____
7. **Are you currently taking any type of Herbal Supplements?** ☐Yes ☐No

   If yes, please list:_____
8. **Are you sensitive or allergic to any medication or anesthetics?** ☐Yes ☐No

   If yes, please list:_____
9. Have you ever taken the diet drug Phen-Phen? ☐Yes ☐No
10. Indicate which of the following you have had or have at the present. Check "yes" or "no" for each item.

Heart Failure	☐Yes ☐No	*Artificial Joints (hip, knee, etc.)	☐Yes ☐No	Hepatitis B (serum)	☐Yes ☐No
Heart Disease or Attack	☐Yes ☐No	Kidney Trouble	☐Yes ☐No	Hepatitis C	☐Yes ☐No
Angina Pectoris	☐Yes ☐No	Ulcers	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Congenital Heart Disease	☐Yes ☐No	Diabetes	☐Yes ☐No	A.I.D.S.	☐Yes ☐No
*Heart Murmur	☐Yes ☐No	Thyroid Problems	☐Yes ☐No	H.I.V. Positive	☐Yes ☐No
High Blood Pressure	☐Yes ☐No	Glaucoma	☐Yes ☐No	Cold Sores/Fever Blisters	☐Yes ☐No
Arteriosclerosis	☐Yes ☐No	Cancer	☐Yes ☐No	Hemophilia	☐Yes ☐No
*Mitral Valve Prolapse	☐Yes ☐No	Emphysema	☐Yes ☐No	Anemia	☐Yes ☐No
Artificial Heart Valve	☐Yes ☐No	Chronic Cough	☐Yes ☐No	Sickle Cell Disease	☐Yes ☐No
*Heart Pacemaker	☐Yes ☐No	Tuberculosis	☐Yes ☐No	Bruise Easily	☐Yes ☐No
Heart Surgery	☐Yes ☐No	Asthma	☐Yes ☐No	Liver Disease	☐Yes ☐No
*Rheumatic Fever	☐Yes ☐No	Seasonal Allergies	☐Yes ☐No	Yellow Jaundice	☐Yes ☐No
Arthritis	☐Yes ☐No	Allergies or Hives	☐Yes ☐No	Epilepsy or Seizures	☐Yes ☐No
Rheumatism	☐Yes ☐No	Sinus Trouble	☐Yes ☐No	Fainting or Dizzy Spells	☐Yes ☐No
Cortisone Medicine	☐Yes ☐No	Radiation Therapy	☐Yes ☐No	Nervousness	☐Yes ☐No
Drug Addiction	☐Yes ☐No	Chemotherapy	☐Yes ☐No	Tumors	☐Yes ☐No
Stroke	☐Yes ☐No	Hepatitis A (infectious)	☐Yes ☐No	Developmentally Disabled	☐Yes ☐No
Low Blood Pressure	☐Yes ☐No	Breathing Problems	☐Yes ☐No	Frequent Diarrhea	☐Yes ☐No
Blood Disease	☐Yes ☐No	Shortness of Breath	☐Yes ☐No	Excessive Thirst	☐Yes ☐No
Hypoglycemia	☐Yes ☐No	Pain in Jaw Joints	☐Yes ☐No	Alzheimer's Disease	☐Yes ☐No

11. Do your ankles swell during the day? ☐Yes ☐No
12. Have you lost or gained more than 10 pounds in the past year? ☐Yes ☐No
13. Are you on a special diet? ☐Yes ☐No
14. Do you have or have you had any disease, condition, or problem not listed? ☐Yes ☐No

    If yes, please list:_____
15. Do you use tobacco products? ☐Yes ☐No
16. Do you use alcohol products? ☐Yes ☐No

FOR WOMEN ONLY:

17. Are you pregnant? ☐Yes ☐No If yes, what month?_____ Are you nursing? ☐Yes ☐No
18. Are you taking birth control pills? ☐Yes ☐No

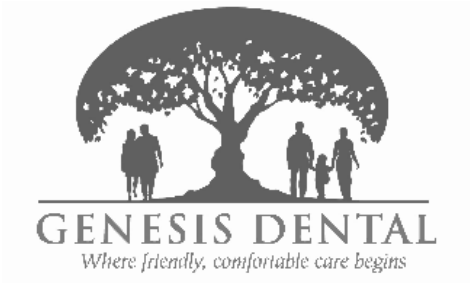
I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

PATIENT SIGNATURE_____ **DATE**_____

PARENT OR RESPONSIBLE PARTY _____ **RELATIONSHIP TO PATIENT** _____

Medical Review:
Reviewed by:_____ Date_____
Reviewed by:_____ Date_____
Reviewed by:_____ Date_____
Reviewed by:_____ Date_____
Reviewed by:_____ Date_____
Reviewed by:_____ Date_____

Medical History Update by Patient:
Initials_____ Date_____
Initials_____ Date_____
Initials_____ Date_____
Initials_____ Date_____
Initials_____ Date_____
Initials_____ Date_____



FINANCIAL

Thank you for choosing us as your dental care provider. We realize that everyone's financial situation is different. For this reason, we have worked hard to provide a variety of payment options so that you can receive the care you deserve with respect to your budget.
Please check the option(s) that will work the best for you.

☐ **Pay As You Go (w/ Insurance Processing)**
You may use Cash, Personal Check, Debit, Visa, MasterCard, Discover, American Express, and Money Order to pay your estimated portion owed at each visit.

☐ **Pay As You Go (No Insurance Processing)**
If we do not have to file insurance claims and wait for payment from an insurance company, we offer a **5% accounting discount** when you pay the **entire balance owed at each visit**. If you do have insurance and still want to take advantage of this discount, we will print the claim for you and you can receive payment from your insurance company.

☐ **Entire Treatment Plan (No Insurance Processing)**
If we do not have to file insurance claims and wait for payment from an insurance company, we offer a **10% accounting discount** for larger cases when you pay **up front for your complete treatment plan (all visits needed) before the start of treatment**. If you do have insurance and still want to take advantage of this discount, we will print the claim for you and you can receive payment from your insurance company.

☐ **Monthly Payments**
With **no down payment** required and **small monthly payments**, this is the most favorable option for many of our patients. We use several different, high quality finance companies which specialize in helping dental patients afford necessary treatment. There is no deposit required, monthly payments can be as low as 3% of the outstanding balance, and terms range from 3 to 48 months. There is **no interest** for any program of 3, 6, or 12 months. Longer terms have reasonable rates (much lower than standard credit card rates) and there is never any prepayment penalty. Approval takes just a few seconds and is done right here in the office.

INSURANCE

It is our pleasure to assist you in maximizing your insurance benefit by completing your claim forms. At the time of service you will be required to pay your **estimated** co-payment. Please understand this is only an **estimate**, and is based upon the information available to us.

Insurance benefit coverage depends solely on what your employer wishes to purchase. Some plans cover as little as 30% or as much as 100% of dental services, with most falling in the 40% to 80% range. Some plans base the amount of benefit on a schedule of fees arbitrarily developed by insurance companies. For this reason, you may receive a lower percentage than the reimbursement level indicated in your dental plan. For example, if your plan states that it will pay 80% of the cost of a specific treatment, it means 80% of the fee arbitrarily determined by the insurance company and not the actual fee charged by our office.

The **financial obligation for dental treatment is between you and our office. The insurance company is responsible to you, and not to our office.** We will assist you in any way we can. Once your insurance carrier has paid the claim, any difference will be due within 30 days. If for any reason we have not received your insurance carrier's payment 90 days after the claim was submitted, the full balance will be your responsibility.

AGREEMENTS AND CONSENT TO PROCEED

- I authorize Genesis Dental to take X-rays, study models, photographs and any other diagnostic aids deemed appropriate by the doctor and to perform any and all forms of treatment, medication, and therapy that may be indicated. I do voluntarily assume any and all possible risks associated with the delivery of such treatment.
- I authorize Genesis Dental to receive payment directly from my insurance company for all services rendered to me and my family.
- I agree to pay monthly interest charges in the amount of 1.5% per month on all charges over 30 days old.
- I agree that should my account ever be referred to an attorney or collection agency, I will pay all costs of collection, including up to 50% collection agency fee, as well as court costs and a reasonable attorney fee.
- I authorize Genesis Dental to obtain a credit report when deemed necessary.
- I have been allowed to review and to receive (if requested) a copy of the offices Notice of Privacy Practices.

_____ _____

Signature of Patient (Parent or Guardian if patient is a minor) Date

Appointment Guidelines

In order to keep an efficient schedule, and to assure that our patients are not subject to long delays in the waiting room prior to seeing the doctor, we pre-reserve all our appointment times. When an appointment is cancelled with less than 48 hours notice it leaves a hole in the schedule and it is often not enough time to allow another patient to rearrange their schedule in order to fill the opening. In order to keep the scheduling efficient and convenient for everyone we have the following appointment guidelines:

CONFIRMATIONS
We call to confirm visits 2 days in advance. If we are not able to speak with you personally, we will leave a message and expect you to call our office and confirm your appointment. All unconfirmed appointments may be booked over and/or rescheduled.

CANCELLATIONS AND RESCHEDULING
We are aware that emergencies and unexpected events arise for everyone, and we will be understanding and respectful of such instances. However, to reduce last minute changes in the schedule, we ask that you speak with our scheduling coordinator a minimum of 48 hours prior to your reserved time if your appointment needs to be cancelled or rescheduled.

The following missed appointment protocols apply:
1 MISSED APPOINTMENT: We will reschedule another time for you.

2 MISSED APPOINTMENTS: We will reschedule your third appointment with a 50% deposit. The deposit is due prior to scheduling your appointment and will go towards that appointment balance. If you are unable to keep this reserved time, the deposit will be non-refundable.

3 MISSED APPOINTMENTS: We realize that we have a significant difference in philosophy and recommend that you secure the treatment of another dentist.

There will be a $50.00 fee assessed to all broken or missed appointments. This fee will need to be paid before any further appointments will be scheduled.

I have read and agree to the guidelines outlined above.

_____ _____
Signature of Patient (Parent or Guardian if patient is a minor) Date