PATIENT INFORMATION

Name ____ Phone # ___________________
Last First Middle
Address: ____ City/State/Zip ________________________
Date of Birth: _____/_____/_____ SS#: __________________
Employer: ____________________ Work # : __________________ May we call you at work? Y or N
Emergency Contact/Relationship: _______________________________ Contact Phone: ________________
How did you hear about us? Friend (please name ______________) Facebook, Website, Google, Other__________
Preferred Pharmacy: ___________________________________ Primary Care Physician _____________________

RESPONSIBLE PARTY (if someone other than patient)

First Name:____________________________ Last Name:_____________________________ MI:____
Address:____City/State/Zip:_________________________________
Home Phone ( )____________________Work Phone ( )___________________Cell Phone( )_____________
Birth Date:___________________ SS#:_____________________ Relationship to Patient:____________________

PRIMARY INSURANCE INFORMATION

Name of Insured________________________Relationship to insured: self spouse child other
Insured SSN/ID__________________________ Insured date of Birth:___________________________
Insurance Company:__________________________ Employer:________________________________
Address:____ Group #:________________________________
City,State,Zip:_________________________________ Phone #:________________________________

SECONDARY INSURANCE INFORMATION

Name of Insured________________________Relationship to insured: self spouse child other
Insured SSN/ID__________________________ Insured date of Birth:___________________________
Insurance Company:__________________________ Employer:________________________________
Address:____ Group #:________________________________
City,State,Zip:_______ _________________________ Phone #:________________________________

ASSIGNMENT & RELEASE: I hereby authorize and request my insurance company to pay directly to Duggan Dental the amount due on my claim for services rendered to me or my dependent. I further agree that should the amount be insufficient to cover the entire dental expense, I will be responsible for payment of the difference: and the nature of the liability be such that it is not covered by the policy, I will be responsible to Duggan Dental for payment of entire bill.

Patient/Guardian Signature:______________________________________Date:________________

Patient Printed Name:____

Patient's Name: ______________________________

DENTAL HISTORY

	Yes	No
Please check any of the following problems that apply to you:	☐	☐
- Sensitivity (hot, cold, sweet, pressure) Where? UR UL LL LR	☐	☐
- Headaches, earaches, neck pain	☐	☐
- Jaw joint pain	☐	☐
- Teeth or fillings breaking	☐	☐
- Grinding or clenching teeth	☐	☐
- Bleeding, swollen or irritated gums	☐	☐
- Loose, tipped or shifting teeth	☐	☐
- Bad breath	☐	☐
Do you have or have you had any of the following?		
- Dentures	☐	☐
- Partial dentures	☐	☐
- Braces	☐	☐
- Periodontal (gum) treatments	☐	☐

Please share the following dates:

- Your last cleaning ______ / ______
- Your last oral cancer screening ______ / ______
- Your last complete xrays ______ / ______

	Yes	No
Do you smoke or use chewing tobacco? How much? ________ For how long? _______	☐	☐
If I could change my smile, I would:		
- Make it whiter	☐	☐
- Make it straighter	☐	☐
- Close spaces	☐	☐
- Replace black, metal fillings	☐	☐
- Repair chipped teeth	☐	☐
- Replace missing teeth	☐	☐
- Replace old crowns that do not match	☐	☐
- Have a smile makeover	☐	☐

Do you have sleep apnea?

ON A SCALE OF 1-10, WITH 10 BEING THE HIGHEST RATING:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you want your current dental health?

1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

Name of Previous Dentist __________________________________

What is the most important thing to you about your smile and dental health? ____

What is the most important thing to you about your dental visit today? ____

MEDICAL HISTORY

Please check any of the following problems/conditions that apply to you:

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV	☐	☐	Drug/Addiction	☐	☐	Depression	☐	☐	Tuberculosis	☐	☐
Anemia	☐	☐	Emphysema	☐	☐	Pacemaker	☐	☐	Ulcers	☐	☐
Angina (chest pain)	☐	☐	Radiation (head/neck)	☐	☐	Pregnant Currently	☐	☐	Respiratory Problems	☐	☐
Arthritis	☐	☐	Excessive Bleeding	☐	☐	Epilepsy	☐	☐	Fever Blisters	☐	☐
Diabetes	☐	☐	Fainting	☐	☐	Venereal Disease	☐	☐	Leukemia	☐	☐
Artificial Joints	☐	☐	Glaucoma	☐	☐	Rheumatic Fever	☐	☐	Dizziness	☐	☐
Asthma	☐	☐	Heart Conditions	☐	☐	Rheumatism	☐	☐	Liver Disease	☐	☐
Blood Disease	☐	☐	Heart Surgery	☐	☐	Scarlet Fever	☐	☐	Low Blood Pressure	☐	☐
Bruise Easily	☐	☐	Hepatitis A, B or C	☐	☐	Herpes	☐	☐	Stroke	☐	☐
Cancer	☐	☐	Kidney Disease	☐	☐	Seizures	☐	☐	Thyroid Disease	☐	☐
Cervical Cancer	☐	☐	HPV	☐	☐	Sinus Problems	☐	☐	Sickle Cell Anemia	☐	☐
Chemotherapy	☐	☐	Jaw Joint Pain	☐	☐	Sleep Apnea	☐	☐	Other: ______________________		
Artificial Heart Valve	☐	☐	High Blood Pressure	☐	☐	Stomach Problems	☐	☐			

Please circle and/or list any allergies:

Penicillin Sulfa Latex Codeine Other: ____

Please circle if you have ever taken any of the following medications?

Bisphosphonates Meloxicam Coumadin Warfarin Herbal Supplements

Are you under a physician's care? What for? ____

Primary Care Physician ______________________________ Phone Number ____________________________________

Please list all medications: ____

____

I understand the above information and attest that this information is accurate and complete to the best of my knowledge. If I have any changes in my health status or if my medications change, I shall inform Duggan Dental. I also give my consent to be treated at Duggan Dental.

_____________________________________ __________ ______________________________________

Patient Signature (or Guardian) **Date** **Dentist Signature**

FINANCIAL POLICY

The following is a statement of our financial Policy, which we require that you read, agree to and sign prior to any treatment.

Welcome and thank you for choosing Duggan Dental for your dental care! We are committed to providing you with the highest quality dental care possible in a cost-effective manner. Please understand that payment of all services is considered part of your treatment. We are happy to discuss with you any questions you may have concerning your financial agreements.

Payment is due at the time service is provided. Our office accepts cash, personal checks, master card, visa, Discover, and American Express.

1. 5% discount on services over $500 with payment in full by cash or check
2. Services involving more than one visit- 50% due at start of treatment. Payments can be spread over the length of treatment but **must** be paid in full prior to completion of treatment.
3. We accept Visa, Mastercard, Discover, American Express and Care Credit.

For patients with dental insurance, we are happy to work with your carrier to maximize your insurance benefits. We will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subjected to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility and due at the time of service. Your insurance benefits are a contract between you and your insurance company, and therefore all disputes must be handled between you and your insurance company. All charges you incur are your responsibility, regardless of your insurance coverage. **As your dental care provider, our relationship is with you, our patient, not with your insurance company. All diagnosed treatment is based on your dental health- not your insurance coverage.**

Minors accompanied by parent or legal guardian: The parent or legal guardian accompanying a minor, who has consented to treatment are responsible for full payment of services.
Unaccompanied Minors: The parent or legal guardian is responsible for full payment of services. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to the appointment or non-emergency treatment may be denied.

Missed appointments and cancellations: Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best services to our patients, we require at least 24 hours notice for cancellations or for re-scheduling your appointments. We understand that unforeseen circumstances may arise, which may result in cancelling or missing your appointment. We reserve the right to bill for missed or cancelled appointments that are not provided with at least 24-hour notice. A fee of $50 will be applied for such instances.

Please indicate your understanding and acceptance of these financial policies by signing below. Please also indicate that you have read and received a copy of Duggan Dental's Notice of Privacy Practices.

X____ **Date**________________________
SIGNATURE OF PATIENT OR GUARDIAN