Patient Information

Patient Name_____ Parent/Guardian Name_____

Birthdate_____ Sex_____ Social Security#_____

Home Address_____City_____State_____Zip_____

Cell Phone_____ Home _____Work _____

Email_____ Emergency Contact_____ Phone_____

Primary Insurance

Policy Holders Name_____

Birthdate_____ Relationship to Patient_____

Insurance Company_____

Insurance Address_____

Insurance Phone #_____

Employer_____

Subscriber S.S #_____

Subscriber ID#_____

Group#_____

Additional Insurance

Policy Holders Name_____

Birthdate_____ Relationship to Patient_____

Insurance Company_____

Insurance Address_____

Insurance Phone#_____

Employer_____

Subscriber S.S#_____

Subscriber ID#_____

Group#_____

Agreement to pay for treatment and insurance billing authorization

I hereby acknowledge full responsibility for the payment of services rendered in behalf of the named patient whether or not they are covered by insurance. I understand payment is expected at the time of service. I understand that check payments may be converted to automatic bank drafts. I agree that if payment is extended beyond 30 days from the date of service to pay a rebilling charge of 1.7% of the unpaid balance, with minimum charge of $5.00 per month. I agree to pay collection costs and/or attorney's fees if a delinquent balance is placed with an agency for collection. I authorize my Insurance company to make payments directly to the dental office for the benefits otherwise payable to me. I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities deemed necessary by this office. I authorize use of this signature for all insurance submissions. I have received a copy of Privacy Practices. I understand that appointments, missed or cancelled without 24 hours' notice are subject to a $131 cancellation fee. I understand that deposits may be required to reserve certain appointment types and/or times. I understand estimates of treatment costs are valid for 90 days. I have reviewed the information on this form, and it is accurate to the best of my knowledge.

Signature_____Date_____

Medical History

Have you been hospitalized? Please explain. _____
Are you under the care of a physician or planning to see one for any reason? Please Explain._____
_____
List any medications you are currently taking. _____
_____
Do you smoke cigarettes? _____ Vape?_____ Cannabis?_____ Drink alcohol? _____
Pregnant?_____ Nursing? _____
Allergies: ☐ latex ☐ penicillin ☐ metal ☐ codeine ☐ sulfa ☐ local anesthetics ☐ other _____

Please check all that apply:

- ☐ AIDS/HIV
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Congenital heart Disease
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting spells/Dizziness
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Heart attack /failure
- ☐ Heart Murmur
- ☐ Heart pacemaker
- ☐ Heart trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ High blood pressure
- ☐ Hypoglycemia
- ☐ Kidney Disease/Problem
- ☐ Liver Disease/Problem
- ☐ Low blood pressure
- ☐ Lung disease
- ☐ Mitral valve prolapsed
- ☐ Pain in jaw joints
- ☐ Parathyroid disease
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stomach disease
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or growths
- ☐ Ulcers
- ☐ STD/Venereal Disease

Any other illness not checked above_____

Dental History

Reason for seeking care today: ☐ Cleaning and Exam ☐ Specific Problem_____

Please check all that apply:

- ☐ Toothache
- ☐ Broken filling or tooth
- ☐ Chipped tooth
- ☐ Sensitivity
  - ☐ Cold
  - ☐ Heat
  - ☐ Sweets
  - ☐ Chewing
- ☐ Food Catches
- ☐ Loose teeth
- ☐ Missing teeth
- ☐ Floss breaks or hurts
- ☐ Missing teeth
- ☐ Floss breaks or hurts
- ☐ Bite or teeth shifted
- ☐ Bite cheeks
- ☐ Dry mouth
- ☐ Bad breath
- ☐ Unhappy with previous work
- ☐ Gums bleed
- ☐ Gums tender
- ☐ Growths or sores
- ☐ Cold sores/fever blisters
- ☐ Cracked or chapped lips
- ☐ Bad taste in mouth
- ☐ Clench or grind teeth
- ☐ Clicking or popping jaw joint
- ☐ Unable to open wide
- ☐ Jaw tires easily
- ☐ TMJ or TMD
- ☐ Wisdom teeth
- ☐ Had braces
- ☐ Want braces
- ☐ Prior gum treatment
- ☐ Prior bite treatment
- ☐ Snore or don't sleep well
- ☐ Sleep apnea
- ☐ Embarrassed about teeth
- ☐ Gag easily
- ☐ Dislike dental office noises
- ☐ Don't like cotton in mouth
- ☐ Uncomfortable lying in dental chair
- ☐ Afraid of needles
- ☐ Difficult to numb
- ☐ Reaction to anesthetic
- ☐ Worried about costs

Would you like whiter teeth?_____ Is there anything that bothers you about the appearance of your teeth or smile?_____
On a scale from 1-10 how anxious are you about dental treatment? (1=relaxed, 10=scared) _____
What did you like most about your previous dentist? _____
Why did you leave your last dentist? _____
Is there anything we can do to make your visits more comfortable? _____

Consent for treatment

To the best of my knowledge the questions on this form have been accurately answered. I will inform Albion Dental of any changes to these answers. I authorize Albion Dental to perform those procedures deemed necessary or advisable to maintain my dental health or the dental health of my child. I understand that dental treatment and anesthesia entails risks such as bleeding, infection, nerve damage, fracture of tooth or bone, injury to muscle, bruising, muscle soreness, swallowing or inhaling small objects, breakage of instruments, pain during and after treatment, abrasions and lacerations to gums, cheeks, or tongue. I do voluntarily assume all possible risks that may be associated with dental treatment in hopes of obtaining desired results.

Signature: _____ Date: _____