

Welcome to Total Dental Care

PATIENT INFORMATION

Today's Date _____

First Name _____ Last Name _____ Middle _____

Address _____ City _____ State _____ Zip _____

Date of birth _____ SSN _____ Driver's Lic _____ Gender: M or F

Home phone _____ Cell phone _____ Email _____

Employer _____ Work phone _____ Occupation _____

Emergency contact: _____ Relation: _____ Phone _____

How did you hear about our practice? _____

I give permission for Total Dental Care and its agents to discuss my private health information, including financial and billing information, with the following individual: _____ Relation : _____
I understand that the above authorization will remain in effect until I revoke it in writing.

For patients under 19:

Who should we contact to confirm appointments? _____ Relation to patient: _____

Phone #1: _____ Phone #2: _____ Email: _____

RESPONSIBLE PARTY

____ Patient is responsible party

____ Another person is responsible for account (person must be present to sign this form, and be at least 19 years of age)

First Name _____ Last Name _____ Middle _____

Address _____ City _____ State _____ Zip _____

Date of birth _____ SSN _____ Driver's Lic _____

Home phone _____ Cell phone _____ Email _____

Employer _____ Work phone _____ Occupation _____

DENTAL INSURANCE INFORMATION

____ No dental insurance

____ Patient is subscriber (*same info as above*)

____ Another party is subscriber and patient is covered on his/her plan:

Subscriber: First Name _____ Last Name _____ Middle _____

Subscriber date of birth _____ Subscriber SSN _____

Subscriber Employer _____ Work phone _____ Other phone _____

Insurance Company _____ Group No _____ Contract No _____

***As the responsible party for this account, I understand that I am legally responsible for the payment of any and all fees for treatment rendered to the patient listed above. If patient is insured, claims will be filed on behalf of patient, but I am ultimately responsible for the total bill, regardless of insurance payment or nonpayment.**

Printed name: _____ Signature: _____ Date _____

TOTAL DENTAL CARE

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?
Have you ever been hospitalized or had a major operation?
Have you ever had a serious head or neck injury?
Are you taking any medications, pills, or drugs?
Do you take, or have you taken, Phen-Fen or Redux?
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
Are you on a special diet?
Do you use tobacco?
Do you use controlled substances?

Women: Are you Pregnant/Trying to get pregnant? Taking oral contraceptives? Nursing?

- Are you allergic to any of the following?
Aspirin, Penicillin, Codeine, Local Anesthetics, Acrylic, Metal, Latex, Sulfa drugs, Other

- Do you have, or have you had, any of the following?
AIDS/HIV Positive, Alzheimer's Disease, Anaphylaxis, Anemia, Angina, Arthritis/Gout, Artificial Heart Valve, Artificial Joint, Asthma, Blood Disease, Blood Transfusion, Breathing Problem, Bruise Easily, Cancer, Chemotherapy, Chest Pains, Cold Sores/Fever Blisters, Congenital Heart Disorder, Convulsions, Cortisone Medicine, Diabetes, Drug Addiction, Easily Winded, Emphysema, Epilepsy or Seizures, Excessive Bleeding, Excessive Thirst, Fainting Spells/Dizziness, Frequent Cough, Frequent Diarrhea, Frequent Headaches, Genital Herpes, Glaucoma, Hay Fever, Heart Attack/Failure, Heart Murmur, Heart Pacemaker, Heart Trouble/Disease, Hemophilia, Hepatitis A, Hepatitis B or C, Herpes, High Blood Pressure, High Cholesterol, Hives or Rash, Hypoglycemia, Irregular Heartbeat, Kidney Problems, Leukemia, Liver Disease, Low Blood Pressure, Lung Disease, Mitral Valve Prolapse, Osteoporosis, Pain in Jaw Joints, Parathyroid Disease, Psychiatric Care, Radiation Treatments, Recent Weight Loss, Renal Dialysis, Rheumatic Fever, Rheumatism, Scarlet Fever, Shingles, Sickle Cell Disease, Sinus Trouble, Spina Bifida, Stomach/Intestinal Disease, Stroke, Swelling of Limbs, Thyroid Disease, Tonsillitis, Tuberculosis, Tumors or Growths, Ulcers, Venereal Disease, Yellow Jaundice

Have you ever had any serious illness not listed above?

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Today's date _____ Patient Name _____ Date of birth _____

SMILE SURVEY

At Total Dental Care, we believe in caring for the total health of our patients. That means watching out for warning signs of potential dental problems, as well as potential health problems. Please circle YES for anything you wish to discuss with the doctor:

How long has it been since you've last seen a dentist? _____

What brings you in today? _____

Are any of your teeth sensitive to hot, cold, biting pressure or sweets? Yes No

Do your gums bleed when you brush or floss? Yes No

Have you ever been told that you have periodontal (gum) disease? Yes No

Are there areas in your mouth that you avoid chewing on? Yes No

Do your jaw joints click, pop or cause pain? Yes No

Are you aware of any nighttime clenching or grinding of your teeth? Yes No

Do you have frequent headaches, tension headaches, or migraines? Yes No

Are you missing any teeth? Yes No

Do your teeth show signs of chipping and wear? Yes No

Do you use tobacco of any kind? Yes No

If yes, in what form? _____ How often? _____

Have you ever been told you have the HPV16 viral infection? Yes No

Do you snore? Yes No

Are you tired, fatigued or sleepy during the day? Yes No

Do you have high blood pressure? Yes No

Do you ever choke or gasp for air while you sleep? Yes No

Have you ever been diagnosed with Obstructive Sleep Apnea? Yes No

If yes, do you wear a CPAP? Yes No

Do you wish your teeth were straighter? Yes No

Do you have spaces that you don't like? Yes No

Do you wish your teeth could be whiter? Yes No

Are there old fillings, crowns or other dental work that you don't like? Yes No

If yes, please explain _____

Are you experiencing any dental problems at this time? Yes No

If yes, please explain _____

What are you looking for in a dental office? _____

Why did you leave your last dentist? _____

If time and money were not an issue, what would you want to change about your smile?

**TOTAL DENTAL CARE
Office Policies**

Please read carefully, initial next to each item, and sign at the bottom.

- _____ Payment in full is expected at the time services are rendered.

- _____ When scheduling an appointment, feel free to ask what the fee will be in advance. We will do our best to estimate the cost of your treatment so you can be prepared.

- _____ For cases of \$500.00 or more, we offer a variety of financing options to fit your budget. These options must be discussed PRIOR to the day of treatment, so please ask our business staff when scheduling your appointment if you will need to make payments.

- _____ If at any time, you should accrue a balance on your account that is more than 60 days past due, Total Dental Care reserves the right to apply interest to that balance at the rate of 2% monthly (minimum charge is \$5.00).

- _____ If your account should become 120 days past due, it will be sent to a Credit and Collection Agency. By signing below, you agree to be responsible for any and all collection fees.

- _____ We do our best to be respectful of your time when you are in our office. We strive to seat you at your specified appointment time, and to complete your treatment in a timely manner. We do not “double-book” in this office; when you make an appointment with us, we reserve a room and a team member exclusively for you. For that reason, we request at least **48 hours notice of a cancellation or change in appointment.**

- _____ If there is a habit of last minute cancellations or no-shows, we reserve the right to apply a \$100 per hour broken appointment fee, and/or to require prepayment in full before a future appointment will be scheduled.

- _____ We will contact you by phone, email and/or text message to confirm your appointments. PLEASE REPLY to our message(s) so we know you plan to be here. If you do not reply, we reserve the right to give your appointment time to someone else who needs it.

- _____ Please turn off your cell phone when you enter the treatment area. We cannot give you the attention and care you deserve if you are texting while in the dental chair.

- _____ Please do not bring small children with you while you are receiving dental treatment. They will not be allowed in the treatment room with you, and our staff is not able to watch them in the play area.

***I have read and understood the above office policies.**

Patient Name (please print) _____

Patient signature _____ Date: _____
(Or parent/guardian if patient is under 19 years of age)

TOTAL DENTAL CARE

Appointment Policy

We do our best to be respectful of your time when you are in our office. We strive to seat you at your specified appointment time, and to complete your treatment in a timely manner. In order to do that, we do not “double-book” in this office; when you make an appointment with us, we reserve a room and a team member exclusively for you.

For this reason, it is very important that you respond when we contact you to confirm an appointment with us. Our convenient online confirmation system allows you to confirm your appointments by text message or email. Or if you prefer, we can call you on the phone. Regardless of the method, we need you to **respond to confirm your appointment**. If you do not respond, we reserve the right to cancel your appointment and give the spot to someone else who needs it.

We request at least **48 hours notice of a cancellation or change in appointment**.

For missed appointments, or appointments canceled the same day, there will be a \$100 per hour broken appointment fee.

Having said this, we understand that emergencies sometimes occur. If there is a legitimate emergency that prevents you from keeping your appointment, please let us know and we will gladly waive this fee.

Please sign below to indicate that you have read, and agree to follow, this policy:

PRINT patient name _____ Date _____

SIGNATURE of patient (or parent/guardian) _____