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? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

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.

____ As a courtesy to you, we will gladly file claims to your insurance company on your behalf. We will also provide an estimate of your out-of-pocket cost for a procedure, and we will collect that estimated amount at the time of service. But please understand that it is only an estimate; there are hundreds of different insurance plans and we cannot and do not know the details of every one.

____ Regardless of any estimate of insurance coverage we may give you, you are responsible for the total treatment fee. If your insurance pays less than we estimated, or does not pay at all, you will be billed for the balance.

____ If your insurance plan has not paid within 60 days, you will receive a bill for the balance. That bill should be paid within 30 days.

____ If at anytime your account should become more than 60 days past due, a recurring 2% finance charge will be applied to your balance (minimum charge of $5.00 per month).

____ If your account becomes 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 any 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 any future appointments are 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.

***Please sign to indicate you have read and understood the above office policies.**

Patient Name (please print) _____

Signature of patient: _____ 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) _____