Pearl DENTISTRY

www.PearlDentistry.Dental

# NEW PATIENT FORM

Name: _____ Date: _____

Preferred Name: _____ Gender: (male)____ (female)____ (other)_____
DOB: _____ SSN #: _____ Email: _____
Street address: _____
City: _____ State: _____ Zip Code: _____
Home phone: _____ Cell Phone: _____
Emergency Contact Name: _____ Phone: _____
Employer: _____ Work Phone: _____
Referred by: _____

## INSURANCE INFORMATION

Name of Insured: _____ DOB: _____ Relationship to patient: _____
Insurance Company: _____Policy/ID #: _____
Group/Employer Name: _____ Group #: _____
Ins. Co. Address: _____Ins. Co. Phone #: _____

**Secondary Insurance**:

Name of Insured: _____ DOB: _____ Relationship to patient: _____
Insurance Company: _____ Policy/ID #: _____
Group/Employer Name: _____ Group #: _____
Ins. Co. Address: _____ Ins. Co. Phone #: _____

## DENTAL HISTORY

Date of your last dental exam: _____ Date of your last cleaning: _____
Do you have any immediate concerns you'd like us to address? **Yes____ No____**

- If YES please explain:_____

_____

On a scale from **1-5, 5** being most terrified, are you fearful of dental treatment? _____

**Please answer the following questions:**

Are you concerned about the appearance of your teeth? **Yes____ No____**
Are you interested in improving your smile? **Yes____ No____**
Are any teeth currently sensitive to biting, sweets, hot, or cold? **Yes____ No____**
Do you avoid or have difficulty chewing or biting heavily any hard foods? **Yes____ No____**
Do you have any problems sleeping, wake up with a headache or with sore or sensitive teeth? **Yes____ No____**
Do you wear, or have you ever worn a bite appliance? **Yes____ No____**
Do your gums bleed when brushing/flossing? **Yes____ No____** Is brushing or flossing typically painful? **Yes____ No___**
Have you ever been treated for or been told you have gum disease? **Yes____ No____**
Have you ever had braces, orthodontic treatment or spacers, or had a "bite adjustment?" **Yes____ No____**

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## MEDICAL HISTORY

Name of Physician:_____ Phone #:_____
Date of last Exam:_____ Are you under medical treatment now?_____
Are you currently taking any medications, supplements, or drugs? **Yes_____ No _____**

- If **YES**, please list here:_____

_____

Have you ever been hospitalized for any surgical operation or serious illness within the last 5yrs? **Yes_____ No_____**

- If **YES** please explain: _____

_____

Do you take, or have you ever taken Phen-Fen, Redux, Fosamax, Boniva, Actonel or any other bisphosphonate medications: **Yes_____ No_____**
Do you use tobacco? **Yes_____ No_____**
Are you allergic to any of the following?
**Aspirin_____ Penicillin_____ Local Anesthetics_____ Acrylic_____ Metals_____ Latex_____ Sulfa Drugs_____**

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

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

**Women:** Pregnant/Trying to get pregnant? **Yes_____ No_____** If **YES**, how many weeks? _____
Breast feeding? **Yes_____ No_____**

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

**Patient Signature**
**(Parent/Guardian):_____Date:_____**

# FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

**INSURANCE:** Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf. Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

**PAYMENT:** Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

UNPAID BALANCE over 90 days old will be subject to a monthly interest of 1.0% (APR 12%). If payment is delinquent, the patient will be responsible for payment of collection, attorneys fees, and court costs associated with the recovery of the monies due on the account.

MISSED APPOINTMENTS: Unless we receive notice of cancellation 48 hours in advance, you will be charged $50. Please help us maintain the highest quality of care by keeping scheduled appointments. I have read, understand and agree to the terms and conditions of this Financial Agreement.

***Patient's signature:*** _____ ***Date*** _____

# COMMUNICATION CONSENTS

## EMAIL CONSENT FORM PURPOSE:

This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. Pearl Dentistry offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. Pearl Dentistry will use reasonable means to protect the security and confidentiality of email information sent and received. However, Pearl Dentistry cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between Pearl Dentistry and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Pearl Dentistry.

***Patient's signature:*** _____ ***Date:*** _____

## TEXT MESSAGE TO MOBILE CONSENT FORM PURPOSE:

This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. Pearl Dentistry offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. Pearl Dentistry will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Pearl Dentistry cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between Pearl Dentistry and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Pearl Dentistry.

***Patient's signature:*** _____ ***Date:*** _____