PATIENT INFORMATION

DATE _____

☐MARRIED ☐SINGLE ☐MINOR ☐MALE ☐FEMALE

NAME _____
LAST FIRST M

SOCIAL SECURITY# _____

ADDRESS _____
STREET APT.# CITY STATE ZIP

BIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME WORK CELL E-MAIL

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: ☐PATIENT ☐GUARDIAN ☐SPOUSE ☐FATHER ☐MOTHER

INSURANCE INFORMATION

MINOR CHILD - MAYNEED TO COMPLETEBOTH BLOCKS FORPARENT INFORMATION
ADULTS - COMPLETE PRIMARYINSURED
DUALCOVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED/ IFNO INSURANCE COMPLETE FOR RESPONSIBLE PARTY				SECONDARY INSURED			
LAST	FIRST		M	LAST	FIRST		M
STREET	CITY	STATE	ZIP	STREET	CITY	STATE	ZIP
HOME	WORK	CELL	E-MAIL	HOME	WORK	CELL	E-MAIL
BIRTHDATE (MO/DAY/YEAR)	RELATIONSHIP TOPATIENT			BIRTHDATE (MO/DAY/YEAR)	RELATIONSHIP TOPATIENT		
EMPLOYER	DENTAL INS. CO			EMPLOYER	DENTAL INS. CO		
SS#	SUBSCRIBER#		GROUP#	SS#	SUBSCRIBER#		GROUP#

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

X _____
Patient or Responsible Party

_____ _____ _____
Date State Driver's License#

Has any member of your family ever been treated in our office?
Yes ☐ No ☐
Whom may we thank for referring you to our office?

_____

METHOD OF PAYMENT

Responsible party currently has an account with this office
Yes ☐ No
☐Payment in full at each appointment (cash or personal check)
☐Payment in full at each appointment (☐VISA ☐MC ☐OTHER)
Card# _____ Exp. Date _____
I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE

If I do not pay the entire new balance within _ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge willbe a periodic rate of % per month (or a minimum charge of $___ for a balance under $___ _, which is an annual percentage rate of ____ % applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

HEALTH HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name_____ Birth date_____ Age

Address_____ Phone_____

City_____ State_____ Zip_____

Why are you now seeking dental treatment? _____

Please answer each question. Check yes or no. If in doubt, leave blank.

	YES	NO
1. Are you in good health now ?	○	○
2. Are you now under the care of a physician ?	○	○
If so, what is the conditions being treated? _____	○	○
3. Have you ever been hospitalized or had a serious illness ?	○	○
If yes, explain _____	○	○
4. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now that previously?	○	○
5. (Women) Are you pregnant? If so, give due date _____	○	○
6. Do you use tobacco in any form ? If yes, how much _____	○	○
7. Do you use alcoholic beverages (more than 2 drinks per day)?	○	○
8. Do you have or have you ever had any of the following ?	○	○

GENERAL	YES	NO
Tire easily, weakness	☐	☐
Marked weight chane	☐	☐
Night sweats	☐	☐
Persistent fever	☐	☐
SKIN		
Eruptions (rash) hives	☐	☐
Change in skin color	☐	☐
EYES		
Visual change	☐	☐
glaucoma	☐	☐
EARS		
Loss of hearing	☐	☐
Ringing in ears	☐	☐
NOSE		
Frequent nosebleeds	☐	☐
Sinus problems	☐	☐
THROAT		
Soreness/hoarseness	☐	☐
NERVOUS SYSTEM		
Stroke	☐	☐
Headaches	☐	☐
Convulsions / epilepsy	☐	☐
Numbness/ tingling	☐	☐
Dizziness / fainting	☐	☐
Psychiatric treatment	☐	☐
RESPIRATORY		
Tuberculosis	☐	☐
Emphsema	☐	☐
Asthma/hay fever	☐	☐
Persistent cough	☐	☐
Sputum production (phlegm)	☐	☐
Cough up bloody sputum	☐	☐
Difficulty breathing while lying down	☐	☐
ENDOCRINE		
Diabetes	☐	☐
Family history of diabetes	☐	☐
Thyroid condition/goiter	☐	☐
Other	☐	☐

HEART/BLOOD VESSELS	YES	NO
Rheumatic fever	☐	☐
Heart murmur	☐	☐
Chest pain/discomfort	☐	☐
Heart attack / trouble	☐	☐
Shortness of breath	☐	☐
Swelling of ankles	☐	☐
High blood pressure	☐	☐
Congenital heart disease	☐	☐
Mitral valve prolapse	☐	☐
Artifical heart valve	☐	☐
Pacemaker	☐	☐
Heart surgery	☐	☐
Other	☐	☐
BONE/ MUSCLES		
Arthritis/rheumatism	☐	☐
Artificial joints / limbs	☐	☐
DIGESTIVE SYSTEM		
Hepatitis	☐	☐
Jaundice	☐	☐
Ulcers	☐	☐
Change in appetite	☐	☐
Black, bloody or pale stools	☐	☐
URINARY		
Kidney disease	☐	☐
Increase in frequency of urination (night)	☐	☐
Burning on urinatioin	☐	☐
Urethral discharge	☐	☐
Bloody urine	☐	☐
Venereal disease	☐	☐
BLOOD		
Bruise easily	☐	☐
Anemia	☐	☐
Blood transfusion	☐	☐
OTHER		
Latex Sensitivity	☐	☐
Radiation therapy	☐	☐
Chemotherapy	☐	☐
Tumors or growths	☐	☐
Cancer	☐	☐
HIV+	☐	☐
AIDS	☐	☐

9. Are you ALLERGIC or have you ever experienced any reaction to the following?

	YES	NO
Local anesthetics (e.g. novocaine)	○	○
Barbiturates/sedatives/sleeping pills	○	○
Penicillin/other anitibiotics	○	○
Aspirin or codeine	○	○
Sulfa drugs	○	○

Other allergies_____

10. Are you taking any of the following ?

	YES	NO
Anitibiotics/sulfa drugs	○	○
Blood thinners	○	○
Blood pressure medication	○	○
Thyroid medicine	○	○
Cortisone/steroids	○	○
Antihistamines/allergy drugs/ cold remedies	○	○
Transquilizers	○	○
Insulin/other diabetes drugs	○	○
Recreational drugs	○	○
Digitalis/other heart medications	○	○
Nitroglycerin	○	○
Aspirin	○	○

Other medication_____

If yes to any of the above, list ***name*** of medication and ***dosage*** below :

1.----------
2.----------
3.----------
4.----------

1. Is there any disease. condition or problem not listed above that you think we should know about, or is there are activity your doctor says you cannot do? Ifso, explain----------

12. Physician's Name_____Phone_____

13. Have you ever had any serious trouble associated with previous dental treatment ?_____

14. Does dental treatment make you nervous? No._____Slightly_____Modeately_____Extremely_____

15. Date of last dental visit ----------

16. Have you ever been treated for periodontal disease (gum disease. pyorrhea, trench mouth) ?_____
If so. when? _____

17. Do you have or have you ever had any of the following ?

Mouth

	YES	NO
Bleeding, sore gums	○	○
Unpleasant taste/bad breath	○	○
Burning tongue/lips	○	○
Frequent blisters, lips/mouth	○	○
Swelling/lumps in mouth	○	○
Ortho treatments (braces)	○	○
Biting cheeks/lips	○	○
Clicking/popping jaw	○	○
Diffuclty opening or closing jaw	○	○

TEETH

	YES	NO
Loose teeth	○	○
Sensitive to hot	○	○
Sensitive to cold	○	○
Sensitive to sweets	○	○
Sensitive to biting	○	○
Food impaction	○	○
Clenching/grinding	○	○
Shifting of teeth	○	○
Change in bite	○	○

Oral Hygeine----------

Do you use the following ?	YES	NO
Brush	○	○
Dental floss	○	○
Fluoride rinse	○	○

Other _____

How often do you brush_____

Brush is : Soft ○ Medium ○ Hard ○

To the best of my knowledge, all of the preceding answers are true and correct.
If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient
Parent or Guardian_____Date_____

Financial Policy

Our office DOES NOT EXTEND CREDIT. We do not "bill" the patient. We do however, offer several options for methods of payments so you can choose the one which best suits your personal situation.

A. **Method of payments:** 1. Credit Cards, Visa, MasterCard, Discover, Amex
2. Cash or Check (with proper identification)
3. Third party financing (payment plan)
-Chase health advance care loans
- Care credit

B. **Dental Insurance:** Your estimated Co- payment is due when service is rendered at which any of the above payment methods can be used. Our office cannot be held responsible for our estimate of your benefits. If for any reason your insurance company has not paid within 30 days. The entire balance becomes due and payable by you._____,Initial)

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment to be made directly to Dr Alexis L. Glaser for benefits, which may be due and payable under insurance coverage for the below named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I understand Dr. AlexisDMD is not contracted directly with any insurance plan. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to the above named doctors._____,Initial)

WE DO NOT BILL PATIENTS:

DrAlexisDMD is a fee for service practice and as such collects for services at the time they are rendered. As a courtesy to patients that have insurance we will bill the insurance company and await payment. This is not an obligation but is done to help reduce our patients' paper work and out of pocket expenses on their visits. In the event of a balance after insurance or if the insurance takes longer the 60 days to pay we will hold the patient responsible. We require a valid credit/debit card on file at all times when dealing with insurance. This information is kept private and confidential it can and will only be used to keep accounts in good standing.

Card#_____ Card Type: Visa Exp. Date:_____

CVV (security code)____ _ Signature:_____

MISSED APPOINTMENTS:

DrAlexisDMD strives to provide excellent service and quality care in a timely manner. Therefore, we will always do our best to accommodate our patients into our schedule at their convenience. We feel that it is only fair for all appointments reserved to be honored by all patients. In the event that it is impossible for the appointment to be kept, please provide at least 48 hrs. notice of cancelation, to timely accommodate another waiting patient. The office DOES NOT consider a voicemail left on the service or answering machine as notice. The cancelation fee is $50.00 for every 1 hr. reserved of the office's time. This fee will becharged to the credit card information left on file. I agree and fully understand the missed appointment policy._____Initial)

NOTICE OF HIPPA PRIVACY FORMS

I have read the office's notice of privacy practices._____.Initial)

X-RAY EXAMINATION (FOR FEMALES ONLY)

I am aware that the radiation exposure may be harmful to an unborn child. To the best of my knowledge I am not pregnant at the time. I agree to diagnostic x-ray examinations as requested by Dr Alexis L. Glaser..... Initial)

PHOTOGRAPHS AND FILMS:

I further agree to the taking of photographs, films, or other materials showing the condition of my mouth or my treatment for the purpose of documentation, my education and diagnosis, as well as for insurance purposes._____.Initial)

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS EACH OF THE ABOVE PARAGRAPHS AND IS THE PATIENT OR RESPONSIBLE PARTY WITH THE POWER TO EXECTUE THIS DOCUMENT AND ACCEPT THESE TERMS----------Initial)

_____ _____

Signature of Patient or Responsible Party Date Signature of Witness Date

_____ _____

Name of Patient or Responsible Party Name of Witness