SNOWDEN FAMILY DENTAL CARE

NEW PATIENT QUESTIONNAIRE

Patient's Name: (Last) _____ (First)_____ (MI)____

Street Address: _____

_____

(City) (State) (Zip Code)

Home Phone: _____ Work/Cell Phone:_____

E-Mail Address:_____

Soc. Sec. No. _____-_____-_____ Date of Birth:_____ Age:_____

Gender: _____Male _____Female Marital Status: ___Single ___Married ____Other

Spouse's Name: _____ Number of children/Ages: _____

Your Occupation:_____ Employer's Name: _____

Employer's Address:_____

Employer's Phone:_____

Spouse's Occupation:_____ Employer's Name: _____

How did you hear about our office? _____Phone Directory ____Advertisement

_____Location ____Referral from a friend

If Referral, whom may we thank? _____

INSURANCE INFORMATION

*Please fill out this section **ONLY** if you are covered by dental insurance. Be sure to answer all questions. (Respond "See above" where applicable)*

Insurance Company's Name:_____

Address:_____

Group Number:_____

Name of Policy Holder:_____ Relationship to Patient:_____

Policy Holder's Address:_____

Policy Holder's Soc.Sec.No:_____-_____-_____ Date of Birth:_____

Policy Holder's Occupation:_____ Employer's Name:_____

Employer's Address:_____

Are you covered by more than one dental insurance policy? _____Yes _____No

Note: if "yes," please inform the receptionist and you will be given some additional paperwork.

By signing below, I authorize use of this form on all my insurance submissions and release of information to all my insurance carriers. I further authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers. This payment is to be made directly to my doctor. Finally, I permit a copy of this authorization to be used in a place of original and in place of a signature on my insurance forms.

Signature:_____ Date:_____

When turning in this form, please have insurance membership car and your driver's license ready for photo copying. This is will facilitate future check writing and insurance form submission.

SNOWDEN FAMILY DENTAL CARE

NEW PATIENT QUESTIONNAIRE

(For minors)

Patient's Name: (Last) _____ (First)_____ (MI)____

Street Address: _____

_____

(City) (State) (Zip Code)

Home Phone: _____
Soc. Sec. No. _____-_____-_____
Your Soc.Sec.No._____-_____-_____
Gender: _____Male _____Female
Spouse's Name: _____

Work/Cell Phone:_____
E-Mail Address:_____
Date of Birth:_____ Age:_____
Marital Status: ___Single ___Married ____Other
Number of children/Ages: _____

Your Occupation:_____ Employer's Name: _____
Employer's Address:_____
Employer's Phone:_____
Spouse's Occupation:_____ Employer's Name: _____

How did you hear about our office? _____Phone Directory ____Advertisement
_____Location ____Referral from a friend

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Policy Holder's Address:_____
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Policy Holder's Occupation:_____ Employer's Name:_____
Employer's Address:_____
Are you covered by more than one dental insurance policy? _____Yes _____No
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MEDICAL HEALTH HISTORY

Patient's Name: (Last) _____(First)_____(MI) ____
Are you currently being treated for anything? ..... Yes No
If yes, what? _____
Have you ever undergone a surgical procedure? ..... Yes No
If yes, please state the nature of the surgery and give the date it was performed:
_____

When did you have your last physical exam? _____
Physician's Name and Telephone number _____
Have you ever been told that you **need to be pre-medicated** for dental treatment? Yes No
Have you ever had, or do you now have any of the following? (Check if yes):

__ Heart (Surgery, Disease, Attack)	__ Blood Transfusion	__ HIV Positive
__ High Blood Pressure	__ Bruise Easily	__ AIDS
__ Chest Pain	__ Hemophilia	__ Prolong Bleeding
__ Heart Murmur	__ Anemia	
__ Mitral Valve Prolapse	__ Venereal Disease	__ Stroke
__ Artificial Heart Valve	__ Syphilis	__ Seizures
__ Rheumatic Fever	__ Herpes	__ Epilepsy
__ Artificial Joints (hips, knees, etc.)	__ Cold Sores	__ Neurological Disorder
__ Used Fen-phen and/or Redux	__ Fever Blisters	__ Depression
__ Active Tuberculosis	__ Allergies or Hives	__ Hepatitis A, B, C, D, G
__ Prolonged Cough 3-4 weeks	__ Latex Allergy	__ Cirrhosis
__ Bloody Cough	__ Sinus Trouble	__ Liver Cancer
__ Asthma	__ Weight Loss	__ Tumors
__ Night Sweats	__ Tobacco Products	__ Cancer
__ Emphysema	__ Alcohol Use	__ Radiation Therapy
__ Other Respiratory Illness	__ Drug Use	__ Chemotherapy
__ Arthritis/Rheumatism	__ Kidney Trouble	__ Women: Pregnant
__ TMJ Disorder	__ Stomach Disorder	__ Women: Nursing
__ Cortisone Medication	__ Ulcers	__ Women: BC Pills
__ Diabetes	__ Thyroid Problems	__ Diet (Special / Restricted)

Are you taking any medications? ..... Yes No
If yes, list medications: _____
Are you allergic to any of the following medications? (Check if yes):
__ Penicillin __ Codeine __ Aspirin __ Novocaine
If you are allergic to, or have an adverse reaction to any other medications, please explain here: _____
Are you very nervous about dental treatment? ..... Yes No
Do you smoke? ..... Yes No
(Please specify): __ Cigarettes __ Pipes __ Cigar

Signature:_____Date:_____

DENTAL NEEDS

When was your last dental cleaning? _____

Are you experiencing any dental discomfort? ..... Yes No

If yes, please describe the nature of your problem: _____

_____

If you feel you require any of the following, please check the appropriate items:

__ Cleaning	__ Gum Treatment	__ Fillings	__ Fluoride Treatment
__ Implants	__ Dentures	__ Braces	__ Crowns or Bridges
__ Night guard	__ Cosmetic Bonding		__ Teeth Whitening

Have you had dental x-rays recently taken? ..... Yes No

Check if yes,
__ Bitewings Date: _____
__ Panoramic Date: _____
__ Cephalometric Date: _____
__ Full-mouth x-rays Date: _____

Do you have any removable appliances/objects or dentures? ..... Yes No

OFFICE POLICY SUMMARY

Welcome to our office. We are happy to have this opportunity to evaluate, and if necessary, restore your dental health. Please be assured that we are committed to providing you with the highest quality oral health care in the most gentle, efficient and enthusiastic manner possible.

Patient Appointments

Except for emergency situations, you can expect us to be on time for your appointment. We would appreciate the same courtesy. If you find it necessary to reschedule, please provide us with 24 hours advance notice. There will be a **$50.00 fee for canceling an appointment without 24 hours advance notice and/or NOT showing for an appointment.**

Payment Policy

Please be informed that your accounts with a balance aged over 90 days from the date of service, will be subjected to a finance charge of 1.5% monthly (APR 18.00%).

The following payment options are given to our patients. Please **check the option** you prefer to be bound to your account:

____1. **Payment will be made in full at the time that treatment is rendered.** This option is offered to patients who do not have dental insurance. We offer you a **10% discount** on all our regular fees when paying by cash / check. **No discount is available when paying by credit card/debit card.**

____2. **Payment through dental insurance.** This option is offered to patients who have dental insurance and wish benefits to be assigned to our office. If you fall into this category, the following requirements must be met:

-You must allow us to photocopy your dental insurance card.
-All information regarding the policyholder and patient's, such as Date of birth, Social security number must be made available in order for our office to file claims for you.
-After filing and payment is rendered by insurance, a statement of account will be sent to you for the remaining balance due (Your portion per insurance).
-It is the patient/policyholder's responsibility to know their own dental benefits and benefit year maximum.

____3. **Installment payments will be made on a monthly basis.** Either due to lack of dental insurance or to financial hardship, this option may best suit your needs (especially when extensive treatment is required).

Please understand that although, we at times, extend the courtesy of deferring the collection of a portion of our fees until insurance company has sent payment, you are solely responsible for paying those fees. In the event of an insufficient fund for your payment, a returned check fee of $35.00 will be applied to your account, as well as any future payment limited to either cash, cashier check, or credit card. If for some reason your insurance company reneges on its obligation, pays less than was anticipated, or does not make payment within **60 days,** you must pay the balance due. Also, if your account ever becomes more than **90 days** past due making it necessary to institute collection activity against you, you agree to pay collection fee of 35% to 50% of past due balance. These fees will include but not limited to legal cost incurred by us in an effort to prosecute our case against you. Finally, please be informed that we reserve the right to obtain a credit bureau report of your credit history anytime we extend you credit.

Please sign below to indicate that you have read, fully understand, and agree to all that has been outlined above.

Signature:_____ Date:_____