# Welcome

Thank you for choosing to visit our dental office. It is a pleasure to meet you! In order to serve you best, please take a moment to provide us with some important information. Your responses are greatly appreciated.

STALEY SMILES
DENTAL CARE

Today's Date _____

Name _____
First Middle Init Last

Preferred Name _____ Single Married Divorced Widowed

Birthdate _____ Social Security Number _____

Home Address _____

City _____ State _____ Zip _____

Cell Phone _____ Work Phone _____ Home Phone _____

E-Mail Address _____

How Did You Hear About Us _____

Emergency Contact: _____

Relation _____ Phone _____

**Primary Insurance Information**

Insurance Company _____ Phone _____

Employer _____ Group Number _____

Insured's Name _____ Date of Birth _____

Insured's SSN _____ Member ID _____

**Secondary Insurance Information**

Insurance Company _____ Phone _____

Employer _____ Group Number _____

Insured's Name _____ Date of Birth _____

Insured's SSN _____ Member ID _____

# Medical History

Patient's Name_____

Physician's Name_____ Phone Number _____

Date of last visit to physician _____ Reason for visit _____

Please list ALL prescription medications, over-the-counter medications, and supplements you are currently taking. This is **extremely** important! We must know all current meds because they can affect your oral health.

_____

_____

Have you ever taken Fosamax, bisphosphonates, or other medication for osteoporosis _____

Have you ever taken Phen-Phen, Redux, or Pondimin _____

Have you ever been prescribed an antibiotic to take before dental visits _____

**Women:** Are you… Pregnant _____ Due Date _____ Nursing _____ Taking birth control pills _____

**Are you aware of being allergic to any of the following:**

____ Acrylic
____ Aspirin
____ Barbiturates
____ Codeine
____ Dental Local Anesthetics
____ Erythromycin
____ Jewelry / Metals
____ Latex
____ Penicillin
____ Sedatives
____ Sulfa Drugs
____ Tetracycline
____ Other

**Please check if you have or have been treated for any of the following:**

____ AIDS / HIV
____ Acid Reflux
____ Anemia
____ Angina
____ Arthritis
____ Artificial Joint
____ Asthma
____ Blood Disease
____ Cancer
____ Chemotherapy
____ Chest pains
____ Cold Sores / Fever Blisters
____ Congenital Heart Disorders
____ Cortisone Medication
____ Diabetes
____ Drug Addiction
____ Emphysema
____ Epilepsy / Seizures
____ Excessive Bleeding
____ Fainting / Dizziness
____ Frequent Headaches
____ Glaucoma
____ Hay Fever
____ Heart Attack / Heart Failure
____ Heart Murmur
____ Heart Pacemaker
____ Hemophilia
____ Hepatitis
____ Herpes
____ High Blood Pressure
____ Hives / Rash
____ Irregular Heartbeat
____ Kidney Problems
____ Leukemia
____ Liver Disease
____ Low Blood Pressure
____ Lung Disease
____ Lupus
____ Mitral Valve Prolapse
____ Psychiatric Care
____ Radiation Treatments
____ Renal Dialysis
____ Rheumatic Fever
____ Rheumatoid Arthritis
____ Scarlet Fever
____ Seasonal Allergies
____ Shingles
____ Sickle Cell Anemia
____ Sinus Trouble
____ Stomach / Intestinal Disease
____ Stroke
____ Thyroid Disease
____ Tumors / Growths
____ Tuberculosis
____ Ulcers
____ Venereal Disease
____ Yellow Jaundice

Any Illness NOT Listed Above_____

I affirm that the medical information provided here is correct to the best of my knowledge:

_____ _____

Signature Date

# FINANCIAL POLICY

We would like to take this opportunity to welcome you to our office, and to let you know we are committed to providing you with the best possible care for your individual needs. So there is no misunderstanding as to what our financial policy is, please take time to read the following information.

If you **do not** have insurance benefits, **full payment will be due the same day services are rendered.** To assist you we accept Cash, Checks, Discover, MasterCard, Visa, and Care Credit.

If you have insurance benefits, we will file insurance claims as a courtesy to our patients. **Please be advised that your dental insurance is a contract between you and the insurance company,** and your coverage is determined by your employer. All services we recommend for you may not be covered by your plan. Reimbursement rates vary widely between companies, and we cannot predict exactly how much any given insurance policy will pay. **You will be responsible for payment of deductibles, co-pays, and/or uninsured expenses in full the day services are rendered. Any remaining balances not paid by your insurance company after 60 days will be billed to you and considered your responsibility.**

Accounts are considered past due at 60 days from the date of service and at 90 days the outstanding balance will be sent to a collection agency.

You will be provided with an **estimated** cost of treatment so you will be aware of any copay amount due on the day of service. We encourage you to communicate with us regarding any difficulties you might have in meeting your financial obligations.

Time is set aside specifically for you when you make an appointment therefore, a minimum of (1) business day notification is required if you are unable to keep your appointment. Patients canceling without (1) day notice or who do not show up for their appointment will be charged a broken appointment fee of $50.00 per hour. _____ please initial.

By signing below, you acknowledge your understanding of an agreement of these terms.

_____ _____

Signature Date

_____

Print Name