New Patient Dental Intake Form

Patient Information

Name: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Email: _____

Sex: ❑ M ❑ F Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Partnership ❑ Widowed

Employer or School: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Spouse, partner or parent name: _____

Person to contact in case of an emergency: _____ Phone: _____

How did you learn about our practice or whom may we thank for referring you? _____

Who is responsible for your account and payment? (if different from previous listing): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____ Birthdate: _____

Dental Insurance

Insurance company: _____ Phone # _____

Subscriber's Social Security # _____ Group # _____ ID # _____

Address: _____ City: _____ State: _____ Zip: _____

How much is your deductible? _____ How much have you used? _____ What is your annual maximum benefit? _____

Whose name is this insurance under? _____

Employer offering this insurance? _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Secondary Dental Insurance

Insurance company: _____ Phone # _____

Subscriber's Social Security # _____ Group # _____ ID # _____

Address: _____ City: _____ State: _____ Zip: _____

How much is your deductible? _____ How much have you used? _____ What is your annual maximum benefit? _____

Whose name is this insurance under? _____

Employer offering this insurance? _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Dental History

Reason for today's visit: _____

Date of last dental care visit: _____ Date of last dental x-rays: _____

Former dentist's name: _____ Phone: _____

Check if you have any problem with the following:

❑ Bad breath
❑ Bleeding gums
❑ Clicking or popping jaw
❑ Food collection between certain teeth
❑ Grinding teeth
❑ Loose teeth or broken fillings
❑ Periodontal treatment
❑ Sensitivity to any of the following: cold, hot, sweets
❑ Sensitivity when biting
❑ Sores or growth in your mouth

How often do you floss? _____ How often do you brush? _____

Medical History

Your physician: _____ Date of last visit: _____

Have you ever taken any of the groups of drugs collectively referred to as "fen-phen"? ❑ Yes ❑ No

Have you had any serious illnesses or operations? ❑ Yes ❑ No

If yes, describe: _____

Have you ever had a blood transfusion? ❑ Yes ❑ No

If yes, give approximate dates: _____

Women: are you pregnant? ❑ Yes ❑ No

Are you nursing? ❑ Yes ❑ No

Are you taking birth control? ❑ Yes ❑ No

Check if you have or have had any of the following:

- ❑ Anemia
- ❑ Arthritis, rheumatism
- ❑ Artificial heart valves
- ❑ Artificial joints, pins, etc.
- ❑ Asthma
- ❑ Bleeding abnormally
- ❑ Blood disease
- ❑ Cancer
- ❑ Chemical dependency
- ❑ Chemotherapy
- ❑ Circulatory problems
- ❑ Congenital heart lesions
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart murmur
- ❑ Heart problems
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High blood pressure
- ❑ HIV AIDS
- ❑ Jaw pain
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Mitral valve prolapse
- ❑ Pacemaker
- ❑ Radiation treatment
- ❑ Respiratory disease
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Sexually transmitted disease
- ❑ Stroke
- ❑ Swelling of feet or ankles
- ❑ Thyroid problems
- ❑ Tobacco use
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer

List medications you are currently taking and the correlating diagnosis:

Medication	Diagnosis

Please list any allergies you may have:

Allergy	Allergy

To the best of my knowledge, the above information is complete and correct.
I understand that it is my responsibility to inform my doctor if I or my minor child has a change in health.

_____ _____

Patient or Guardian Signature *Date*

FINANCIAL POLICY

Thank you for selecting us as your dental health care providers. Our goal is to provide you and your family with optimal dental care. We want you to feel welcomed and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. That includes understanding your treatment plan as well as our financials policy.

FINANCIAL AGREEMENT:

Patients are expected to pay for our services at the time they are rendered. Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service. Payments may be made using cash, check, Visa, MasterCard and/or Discover. For qualified individuals, we also offer CARECREDIT which is a financing option that is available only for healthcare expenses. We will mail monthly statements to all patients with an outstanding balance after 90 days. Please understand there will be a fee for any additional procedure NOT included in the original treatment plan.

1. You will be responsible for any and all costs incurred in the collection of your debt. (i.e. collection agency fees, court fees and/or attorney fees).
2. Fees will apply for any check that is returned by the bank.
3. MINOR PATIENTS: In the case of divorced or separated parents, the parent/guardian present at the time of treatment presentation is to be made responsible for patient's financial arrangement.

Insurance Information:

As a courtesy to our insured patients, we submit claims to your insurance company free of charge. We will help you receive your maximum allowable benefits. In order to do this we need your insurance card and/or insurance policy with you on your first visit for every policy year (your insurance year may not run January – December)

1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relation is with you; not your insurance company.
2. Although we may estimate your insurance benefits, we are not responsible for their accuracy. All charges not paid by your insurance company is your responsibility regardless of the reason for nonpayment. Not all services we provide are covered benefits, which differ from one insurance company to another.

Our doctors will diagnose treatment based on your dental health not your insurance coverage.

I have read and understand this document in its entirety; outlining the office and financials policies of Belmont Dental Associates.

Signature of patient or parent/guardian: _____

Date: _____