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**ADULT NEW PATIENT FORMS**

(please print & use ink)

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First MI (preferred name)

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street City State Zip Code

Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_

Gender:\_\_\_\_\_\_\_ Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student Status: Full-Time Part-Time Not A Student

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Home Work Cell

Contact me by: Phone Text E-Mail Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Driver's License #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How did you learn about our office?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Full-Time Part-Time Retired

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name Phone # Relationship

**The RESPONSIBLE PARTY** is the person held accountable for the patient's dental bill and is the patient unless the patient is a minor, under age 19, or an incapacitated adult.

**Responsible Party Information**: I'm the patient, see above **OR** See info listed below

Name: \_\_\_\_\_\_\_\_\_\_

 Last First MI Relationship to Patient Birth Date

Address:

 Street City State Zip Code

Phone:

 Home Work Cell Social Security Number

Drivers License #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Full-Time Part-Time

**Primary Insurance:** Policy Holder Name: \_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Company Name Mailing Address Phone Number

Policy/Subscriber/Member Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Employer: Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance:** Policy Holder Name: \_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Company Name Mailing Address Phone Number

Policy/Subscriber/Member Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Employer: Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ASSIGNEMENT & RELEASE:** I authorize payment by my insurance carrier to this dental office for care provided to me and/or my dependents. I understand that I am financially responsible for all charges, whether or not covered by insurance.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Parent/Guardian Date

**HEALTH HISTORY** forPatient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

 Last Name First Name MI

Do you take an antibiotic routinely before a dental appointment? \_\_\_No \_\_\_Yes If yes, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list below any medications you current take, including vitamins and over-the counter medications:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take medication for Osteoporosis? \_\_\_No \_\_\_Yes, I take/took: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you see your physician on a regular basis for any condition? \_\_\_ No \_\_\_Yes If yes, for?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name Address Phone Number

Have you ever had any serious illness or operation? \_\_\_ No \_\_\_ Yes If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? \_\_\_ No \_\_\_Yes Do you chew tobacco? \_\_\_ No \_\_\_Yes How much of either?\_\_\_\_\_\_\_\_\_\_

Do you use recreational drugs? \_\_\_No \_\_\_Yes How often do you drink alcohol? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any allergic reaction to: Local Anesthetics (like Novocain) \_\_\_No \_\_\_Yes, \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Penicillin or other antibiotics? \_\_\_No \_\_\_Yes, \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Sulfa Drugs \_\_\_No \_\_\_Yes

 Sedatives \_\_\_No \_\_\_Yes, \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Iodine \_\_\_No \_\_\_Yes

 Aspirin \_\_\_No \_\_\_Yes

 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Women only, are you: Pregnant \_\_\_No \_\_\_Yes If yes, due date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Nursing \_\_\_No \_\_\_Yes Taking birth control pills \_\_\_No \_\_\_Yes

**Please check the following health conditions that you have or had in your lifetime:**

 Aids or HIV Positive Diabetes (type1 or type 2) Liver Disease

 Alcohol Dependency Epilepsy/Seizures Low Blood Pressure

 Alzheimer's/Dementia Excessive Bleeding Lung Disease

 Anemia Fainting/ Dizziness Mental/Nervous Disorder

 Arthritis Glaucoma Pacemaker

 Artificial Heart Valve Head or Neck Injury Pre-Med before dental appt

 Artificial Joint, \_\_\_\_\_\_\_\_\_\_\_\_\_ Head or Neck Growths Radiation/X-ray Treatment

 Asthma Heart Attack Respiratory Problems

 Back problems Heart Disease Rheumatic Fever

 Blood Disorder/Disease Heart Murmur Seasonal Allergies

 Blood Transfusion Hepatitis Sinus Problem

 Breathing Problems Herpes/Fever Blisters Stroke

 Bruise Easily High Blood Pressure Tuberculosis

 Cancer of \_\_\_\_\_\_\_\_\_\_\_\_\_\_ High Cholesterol Venereal Disease

 Chemical Dependency Jaundice OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Chemotherapy Kidney Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Do you have any health problems that need further clarification? No Yes, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Guardian Date

**DENTAL HISTORY** for Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last Name First Name MI

Former Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name Address Phone Number

Date of Last Dental Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last X-rays: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you brush? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, using: electric toothbrush manual toothbrush

Type of bristle: soft medium hard How often to you floss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you lost any teeth? Yes No Would it bother you if you lost any of your teeth? Yes No

 **Reason for today's appointment with us**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_

Please check all that apply to you now, or in the past:

 Bad Breath

 Bleeding Gums

 Blisters on Lips or Mouth

 Broken Fillings

 Finger Nail Biting

 Frequent Headaches

 Grinding Teeth

 Jaw Clicking or Pain

 Jaw, Head or Neck Injuries

 Lip or Cheek Biting

 Loose Teeth

 Oral Cancer

 Orthodontic Therapy

 Pain in Jaw/Around Ear(s)

 Sensitivity to Cold

 Sensitivity to Hot

 Sensitivity to Sweets

 Sensitivity when Biting

 Tooth Pain

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Have you ever been told you have periodontal (gum) disease? No Yes

 If yes, did you complete recommended treatment? No Yes

 If yes, when and where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If yes, have you been keeping periodontal maintenance appointments every 3 months? No Yes

* Have you ever been told you need orthodontic treatment? No Yes

 If yes, did you complete recommended treatment? No Yes

 If yes, when and where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Is there anything about your smile that you do not like? No Yes

 If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* If you are missing teeth, have you ever considered dental implants as a replacement option? No Yes

Please list any other dental information you feel it is important to share with us:

To the best of my knowledge, all of the preceding answers and information regarding my health history and my dental history are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Parent or Guardian Date

**ALLURE DENTAL NEW PATIENT AGREEMENT**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please read & INITIAL each item below. Your understanding of these items allows us to make your dental care our priority and the business end of things easy for both of us. This document covers you and your dependent children.

**\_\_\_\_ Appointment Guidelines:** I agree to respect the appointment times reserved for me. I understand that this dental team asks for ***at least*** 48 business hours if I need to move or cancel an appointment since late cancellation or failure to show for an appointment causes ‘schedule distress’ to the dental office. I also understand that I *may* be charged a late cancelation fee, based on the reason, for a missed or failed appointment and that the dental team has the right to refuse to reschedule me if I late cancel too often or miss too many appointments.

**\_\_\_\_ Assignment of Benefits**:    I authorize this dental office to submit dental claims on my behalf or for my dependents so that claim payment can be made directly to this dental office. I understand that this dental office has no control over how my dental insurance pays on claims but that they will make every effort to ensure that my dental benefits are properly utilized.

**\_\_\_\_ Care to Minor Children:** I understand that the adult who brings a minor child to a dental appointment assumes the financial responsibility for care to that minor. I understand that this office will not get involved in custody, divorced/separation arrangements, etc.  Per Nebraska law, a minor is a young person under the age of 19.

**\_\_\_\_ Message Policy:**I authorize calls to my home, work and/or cell phone as well as text and/or email to confirm appointments for me and/or family members. I also approve verbal messages and voice mail messages regarding my dental appointments. I understand that any contact information I provide will be utilized to confirm appointments unless I specific otherwise.

**\_\_\_\_ Minor Children in the office:** By law patients ***under*** the age of 19 are considered minors. We require a parent or guardian be with minor children at their dental appointments unless arrangements are made with the Business Manager prior to the appointment. A parent/guardian may be allowed in the exam room if the parent/guardian feels it will be beneficial to the minor child. However, sometimes children behave better without a parent/guardian present.

**\_\_\_\_ Patient Privacy Laws:**    I know I can request a copy of Notice of Privacy Practices in compliance with HIPAA (Health Insurance Portability and Accountability Act) as part of my New Patient Packet or at any time. I understand that my patient records are protected from disclosure to anyone other than my insurance carrier and health care provider unless I list additional persons in the Records Release section below.

**\_\_\_\_ Payments:**  I understand that all dental charges are my responsibility, with or without dental insurance & agree to pay my estimated patient portion at the time of service. I understand that my relationship is with this dental office & my dental insurance is a 3rd party in this health care relationship.  This dental office accepts payment via cash, check, credit card & Care Credit. I understand I will be asked to sign a Financial Form & Consent Form before any dental care is scheduled and that the Consent Form also verifies my financial responsibility.

**\_\_\_\_ Photos/Videos:** I authorize members of this dental team to take photos and/or video of my face, jaws and teeth before, during and after treatment, and that my name or other identifying information will be kept confidential. I understand I will not be compensated for any photo or video taken or used. I understand that any photo or video taken can be used for marketing, dental records, dental education or research.

**Records Release:** Is there anyone family member, friend, etc. you want us to share your information with?

  Name & Relationship to Patient Name & Relationship to Patient

 \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

Patient/Guardian Signature                  Date Dental Office Rep Signature                      Date