

Patient Information

Patient Name: _____ Date: _____

Birth Date: _____ Gender: F ___ M ___ Social Security #: _____
Last, First MI (Preferred Name)

Phone (Home): _____ (Cell): _____

Address: _____
Street Apartment #

City _____ State _____ Zip Code _____

Status- Circle one: Single, Married, Divorced, Widow, Child (Skip to *Section 2*)

Employer _____ Phone _____ Ext. _____

Employer Address _____

Spouse's Name _____ Spouse's Employer _____
City State Zip Code

Spouse's Birth Date _____ Social Security # _____

Emergency Contact:

Name _____ Phone _____ Relationship to Patient _____

Address _____

Person Responsible for Account _____ E-mail: _____

Preferred appointment times: Morning Afternoon Evening Any Time M T W Th F S

Preferred confirmation methods: E-mail Text Both

Section 2: Minor

Child resides with: Mother ___ Father ___ Both ___ Legal Guardian _____
Relationship to Child

Mother's Name _____ Address _____
If different than above

Phone _____ Birthdate _____ Social Security # _____

Father's Name _____ Address _____
If different than above

Phone _____ Birthdate _____ Social Security # _____

18 years and older: Full time Student Yes or No School Attended _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend/ relative Dental Office
 Mailer Yellow Pages Newspaper School Work Other _____

Name of person or office referring you to our practice: _____

Insurance Information

Primary
Name of Insured: _____ Insured's Birth Date: _____ ID #: _____

Insured's Employer Name: _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____ Phone _____

Dental History

Please check any of the following problems that apply to you.

- Sensitivity (hot, cold, sweet)
Where? UR LR UL LL
- Headaches, earaches, neck pain
- Jaw joint pain
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen or irritated gums
- Loose, tipped or shifting teeth
- Bad breath

Do you have or have you had any of the following?

- Night Guard
- Braces
- Deep Cleaning / Gum treatments
- Dentures / Partial Dentures

Please share the following dates:

Your last cleaning ___/___

Your last complete X-Rays ___/___

Name of Previous Dentist _____

Phone Number _____

What is the most important thing to you about your future smile and dental health?

Do you smoke or use chewing tobacco?

How much? ___ For how long? _____

I would like to discuss the following for my smile:

- A Whiter Smile
- A Straighter Smile
- Closing spaces
- Replacing black metal fillings with tooth colored restorations
- Replacing missing teeth
- Repairing chipped teeth
- Replacing old crowns that don't match
- Having a smile makeover

On a scale of 1 — 10, with 10 being the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

What did you like best about past dentists?

What is the most important thing to you about your dental visit today?

Medical History

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Epilepsy | Avg Daily BP ____/____ | <input type="checkbox"/> Scarlet Fever |
| _____ | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Jaundice | (No Heart Murmur) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Artificial Joints: | <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Mitral Valve Prolapse | Acid Reflux <input type="checkbox"/> Y or <input type="checkbox"/> N |
| Year Placed _____ | <input type="checkbox"/> Heart Lesions (Congenital) | <input type="checkbox"/> Nervous/Depression | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Phen Fen(1month+) | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis C | Due date: _____ | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Radiation (head/neck) | <input type="checkbox"/> Venereal Disease |
| Avg. Daily Blood Sugar _____ | | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> OTHER: _____ |

Do you have any of the following allergies?

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Valium |
| <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Other |
| <input type="checkbox"/> Codeine | |

Are you under a physician's care? Please describe.

Are you taking any medications? Please List.

Name and phone number of Family Physician

Patient Signature (Parent/Guardian) Date

Dentist Signature Date



FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. Outside financing is available upon request and approval.

Please check if you would like more information about financing options.

Please Note: Returned checks will be subject to additional fees.

Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which the estimated amount that is not covered by your insurance company, by cash, check, MasterCard, Visa or Discover at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO AHOYT FAMILY DENTAL.

CONSENT:

The undersigned hereby authorizes Ahojt Family Dental to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Ahojt to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I agree that a machine-reproduced copy of this signed authorization agreement shall be deemed an original.

Patient Signature(Parent of Child) _____ Date _____