bondds DENTAL STUDIO

Patient Information

Patient Name: _____ Date: _____
Last First MI

Birth Date: _____ Gender: ◯ F ◯ M Social Security #: _____

Phone (Home): _____ (Cell): _____

Address: _____
Street Apartment#

_____
City State Zip Code

Status (Check One): ◯ Single ◯ Married ◯ Divorced ◯ Widow ◯ Child (Skip to *Section 2*)

Employer: _____ Phone: _____ Ext. _____

Employer Address: _____
City State Zip Code

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

Spouse's Birth Date: _____ Social Security Number: _____

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 ☐ Phone (Please check all that apply)

Information for Minors 14 yrs and Older

Child resides with: ◯ Mother ◯ Father ◯ Both Legal Guardian: _____

Mother's Name: _____ Address: _____

Phone: _____ Birthdate: _____ Social Security#: _____

Father's Name: _____ Address: _____

Phone: _____ Birthdate: _____ Social Security#: _____

18 years and older: Full Time Student ◯ Yes ◯ 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 ☐ YMCA ☐ Other _____

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

Insurance Information

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: _____

_____

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Dental History

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

- ☐ Sensitivity (hot, cold, sweet)
  Where ☐ UR ☐ UL ☐ LR ☐ LL
- ☐ Headaches, earaches, neck/shoulder pain
- ☐ Joint pain, clicking or popping of the jaw
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth while awake or asleep
- ☐ Bleeding, swollen or painful gums
- ☐ Loose, tipped or shifting teeth
- ☐ Snoring
- ☐ Sleep Apnea
- ☐ 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 _____

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

○ ○ ○ ○ ○ ○ ○ ○ ○ ○

Do you feel nervous about having dental care? ○ Y ○ N

Do you smoke or use chewing tobacco? ○ Y ○ N

Have your parents experienced gum disease or tooth loss? ○ Y ○ N

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

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

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 future smile and dental health?

Medical History

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

- ☐ AIDS
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints: Year Placed
- ☐ Asthma
- ☐ Bisphosphonate Therapy (ex. Fosamax, Boniva, Actonel)
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Cold Sores
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug Addiction
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Excessive Bleeing
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart Conditions
- ☐ Heart Lesions (Congenital)
- ☐ Heart Murmur
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV Positive
- ☐ High Blood Pressure Average Daily BP
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Pregnant Currently Due date:
- ☐ Radiation (head/neck)
- ☐ Respiratory Proplems
- ☐ Rheumatic Fever
- ☐ Scarlet Fever (No Heart Murmur)
- ☐ Sinus Problems
- ☐ Seizures
- ☐ Stomach Problems Acid Reflux ○ Y ○ N
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other:

Do you have any of the following Allergies?

- ☐ Latex
- ☐ Penicillin
- ☐ Local Anesthetic
- ☐ Nitrous Oxide
- ☐ Tetracycline
- ☐ Codeine
- ☐ Erythromycin
- ☐ Sulfa
- ☐ Valium
- ☐ Aspirin
- ☐ Other

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

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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 BONDDS DENTAL STUDIO.

CONSENT:
The undersigned hereby authorizes Bonnds Dental Studio 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. Hyvel 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: _____ Date: _____

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DENTAL STUDIO

Credit Card Form

Patient Name: _____ Date: _____

Last First MI

Billing Address Information

_____

Street Apartment#

_____

City State Zip Code

Credit Card Information

Name on Card: _____

Credit Card Number: _____

Expiration Date: _____ Security Code: _____

Card Type: ◯ Visa ◯ MasterCard ◯ Discover ◯ American Express

Patient Consent

I authorize Bondds Dental Studio to charge a $75 fee to my credit card if cancelation is not made within 24-hours of appointment or not present the day of the appointment.

By signing below, I acknowledge that I have read and understand the details.

Signature: _____ Date: _____