

PATIENT INFORMATION

first name nickname date of birth
last name gender
mailing address marital status
city state zip social security #
email address home phone
Who may we thank for referring you to our office? cell or pager

EMPLOYMENT INFORMATION

patient's employer occupation
employer address
city state zip work phone

INSURANCE INFORMATION

insured person's name date of birth
insured person's employer social security #
mailing address
city state zip
dental insurance carrier group #
mailing address
city state zip phone

RELATIVE INFORMATION

name of nearest relative relationship
address
city state zip phone

The above information is true and correct to the best of my knowledge. I authorize and give consent to perform dental services agreed between Doctor and Patient and/or Guardian to be necessary or advisable, including the use of local anesthesia and other medication as indicated. I understand that, regardless of insurance coverage, I am responsible for payment of services rendered and that a finance charge of 1.75% will be applied, per month, to accounts past due 60 days or more

patient signature date

visa or mastercard # expiration date








I authorize Glen Park Dental to submit charges to cover balances due 120 days or more.

patient signature date

WELCOME to Glen Park Dental. It is our pleasure to have you as our patient. Our commitment is to provide you with the best possible dental care and to keep you informed of treatment recommendations and financial obligations.

If you have dental insurance, we will be glad to help you to receive your maximum allowable benefits.

The following is our office payment policy:

-  Payment is due at the time services are rendered. We accept Cash, Checks, MasterCard, Visa & Discover.
-  If you are a patient with insurance, it is important to remember that your insurance plan is a contract between you, your employer, and the insurance company. The contract is in no way a binding obligation between the Dental Insurance Company and Glen Park Dental.
-  Our fees generally fall within the acceptable range of the maximum allowance determined by each insurance carrier. This applies only to companies, which pay a percentage of "Usual, Customary, and Reasonable," rates. This does not apply to companies, which reimburse based on an arbitrary "schedule" of fees.
-  After your initial exam you will receive a treatment plan which estimates your portion of payment. If we estimate and collect your co-payment and the insurance underpays or denies a benefit, you are responsible for the remaining balance.
-  While discouraged, a submitted insurance pre-estimate may be sent to your insurance company if you request this. The fee for this pre-estimate is \$50.00.
-  Not all services are covered in all insurance contracts. Insurance companies arbitrarily select certain procedures they do not cover, based upon the premium/contract arranged by your employer.
-  In order for us to help you process your insurance claim for your reimbursement, please bring all insurance information with you. Also, please call your dental insurance carrier to expedite claims if a claim is not paid within 30 days, as the law requires.

Returned checks and outstanding balances over 60 days are subject to collections fees and an interest rate charge of 1.75% per month. There is also a charge for broken appointments and those canceled without 48 hours notice. Please remember that the staff sets aside a designated amount of time for your particular type of treatment. If you miss an appointment without notifying our office, you will be required to pay 50% of the value of your next appointment (non-refundable) before scheduling. If you miss two scheduled appointments without notifying our office, you will be dismissed. We appreciate your understanding of how important keeping appointments is to the doctor and our other patients.

We hope by presenting our policies to you in the beginning, we will avoid any misunderstandings and, therefore, have more time to dedicate to your dental care. If you have any questions regarding the above information or insurance coverage, please do not hesitate to ask ...we are here to help!

patient signature

date

Medical history for

(Your medical history is confidential and necessary for our files and for your health.)

GENERAL INFORMATION

yes no

- Is your health good?
- Has there been a change in your health within the last year?
- Have you been hospitalized or had a serious illness? If so, please explain below.

Date of last medical exam Date of last dental exam

- Are you being treated by a physician now? Your physician's name
- For what? Your physician's phone

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?

yes no

- chest pain (Angina)
- swollen ankles
- shortness of breath
- joint pain, TMJ syndrome
- persistent cough, coughing up blood
- bleeding problems, bruising easily
- sinus problems
- frequent vomiting, nausea
- jaundice

yes no

- dizziness
- headaches
- ringing in ears
- fainting spells
- difficulty urinating, blood in urine
- seizures
- excessive thirst
- dry mouth

DO YOU CURRENTLY HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

yes no

- heart disease
- heart attack, heart defects
- heart murmurs
- rheumatic fever
- blood disorder (sickle cell/hemophilia)
- stroke, hardening of arteries
- high blood pressure
- diabetes
- TB, emphysema, or other lung diseases
- hepatitis A or B, or other liver diseases
- stomach problems, ulcers
- allergies to drugs, food or medications

yes no

- broken bones
- AIDS or HIV+
- eye diseases
- skin diseases
- anemia
- herpes
- VD (syphilis or gonorrhea)
- cold sores or fever blisters
- kidney, bladder disease
- thyroid, adrenal disease
- tumors/cancer

If any, please explain

: MORE MEDICAL HISTORY :

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

- | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--|
| yes | no | | yes | no | |
| <input type="checkbox"/> | <input type="checkbox"/> | psychiatric care | <input type="checkbox"/> | <input type="checkbox"/> | hospitalization |
| <input type="checkbox"/> | <input type="checkbox"/> | radiation treatments | <input type="checkbox"/> | <input type="checkbox"/> | blood transfusions |
| <input type="checkbox"/> | <input type="checkbox"/> | chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> | surgeries (If any, please explain below) |
| <input type="checkbox"/> | <input type="checkbox"/> | prosthetic heart valve | | | <input type="text"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | artificial joint or pins | <input type="checkbox"/> | <input type="checkbox"/> | pacemaker |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | contact lenses |

ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING?

- | | | |
|--------------------------|--------------------------|---|
| yes | no | |
| <input type="checkbox"/> | <input type="checkbox"/> | recreational drugs. If so, which types? <input type="text"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | drugs, medicines. If so, which types? <input type="text"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | tobacco in any form. If so, how much and for how long? <input type="text"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | alcohol. If so, how much and how often? <input type="text"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | redux or fen fen |

- | | | |
|--------------------------|--------------------------|---|
| yes | no | |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any or have you had any other diseases or medical problems not listed on this form? If so, please explain. <input type="text"/> |

QUESTIONS FOR WOMEN

- | | | |
|--------------------------|--------------------------|--|
| yes | no | |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you/could you be pregnant or nursing? If pregnant, how many months? <input type="text"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you taking birth control pills? Type and dose? <input type="text"/> |

SMILE DESIGN

- | | | |
|--------------------------|--------------------------|--|
| yes | no | |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you satisfied with the appearance of your teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Would you like a whiter smile? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had orthodontic (braces) treatment? |
| <input type="checkbox"/> | <input type="checkbox"/> | Would you like straighter teeth? |

To the best of my knowledge, I have answered every question on this form completely and accurately. I will inform my dentist of any change in my health and/or medication.

patient signature date