Soft DENTAL

Patient Information

Patient Name: Last:_____ First: _____ MI: ___ Preferred Name: _____
Gender: ❑ Male ❑ Female Family Status: ❑ Married ❑ Single ❑ Child ❑ Other
Birth Date: _____ **E-mail Address:** _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: Home: _____ Work: _____ ext: _____ Cell: _____
Emergency Contact's Name: _____ Phone Number:_____
Relationship to Patient:_____
Preferred appointment reminder: ❑home phone ❑cell phone ❑text message ❑e-mail ❑work phone

Whom may we thank for referring you to our practice?
Name/Source: _____

Spouse or Responsible Party Information

The following is for: ❑ the patient's spouse ❑ the person responsible for payment ❑ neither – not applicable
Name: Last:_____ First: _____ MI: _____
Gender: ❑ Male ❑ Female Family Status: ❑ Married ❑ Single ❑ Child ❑ Other
Birth Date: _____ E-mail Address: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: Home: _____ Work: _____ ext: _____ Cell: _____

Employment Information

The following is for: ❑ the patient's spouse ❑ the person responsible for payment
Employer Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

Primary Dental Insurance

Name of Insured: Last:_____ First: _____ MI: _____
Insured's Birth Date: _____ ID# or PMI# _____ Group #_____
Insured's Address:_____ City: _____ State: _____ Zip: _____
Insured's Employer Name: _____ Phone: _____
Employer Address: _____ City: _____ State: _____ Zip: _____
Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other
Insurance Plan Name: _____ Phone: _____
Insurance Address: _____ City: _____ State: _____ Zip: _____

Secondary Dental Insurance

Name of Insured: Last:_____ First: _____ MI: _____
Insured's Birth Date: _____ ID# _____ Group #_____
Insured's Address:_____ City: _____ State: _____ Zip: _____
Insured's Employer Name: _____ Phone: _____

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

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

Insurance Plan Name: _____ Phone: _____

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

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of 30 days from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay for the services at the time of treatment, or within five (5) days of receipt of billing statement. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.
I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.
I certify that I, and/or my dependent(s), have insurance coverage with the insurance company I listed on this form and assign directly to Soft Dental all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Soft Dental may use my health care information and may disclose such information to the insurance company (companies) listed on this form and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed one year from the date attached to this form.
I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian (responsible party): _____

Relationship to patient: _____ Date: _____

I understand that Soft Dental is not an in-network provider for Medicare and if I have a Medicare affiliated dental insurance plan with only in-network benefits they will not pay for any services I receive at Soft Dental. I am aware that Soft Dental and myself may not send a claim to my insurance. I assume full financial responsibility for my treatment and will pay for services I receive at Soft Dental.

Patient Signature_____Date_____

I GIVE PERMISSION FOR THE FOLLOWING PEOPLE TO HAVE ACCESS TO MY DENTAL RECORDS:

NAME:_____RELATIONSHIP:_____

DENTAL

Medical & Dental History

Patient Name: Last:_____ First: _____ MI: ___ Preferred Name: _____
Gender: ❑ Male ❑ Female Family Status: ❑ Married ❑ Single ❑ Child ❑ Other
Birth Date: _____ E-mail Address: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: Home: _____ Work: _____ ext: _____ Cell: _____

Answers to the following questions will help the dentist decide how to best treat your dental problems. If you do not know the answer to a question, please leave it blank. If you need any help in completing the form please tell the receptionist. This information is confidential.

Dental History

Who was your previous dentist? _____ When was your last visit to the dentist? _____
Address of previous dentist: _____
Were x-rays taken at your last visit? ❑ Yes ❑ No
If X-rays were taken, what kind was taken? ❑ Full Mouth Series ❑ Panoramic X-ray ❑ Bite Wings (molars only)
What was the reason for your last dental visit and what was done? For example: Toothache, cleaning or fillings. _____
_____
Why did you leave that dentist? _____
What did you like most about your previous dentist (s)? _____
What did you like least about your previous dentist (s)? _____
Has any dental treatment been recommended to you that you have not had done? If so, please explain: _____
_____
Are you aware of any dental problems? ❑ Yes ❑ No Please explain: _____
_____
What do you feel is the present condition of your mouth? _____
Have you ever been treated for gum disease? ❑ Yes ❑ No If yes, what was done? _____
Are your teeth sensitive to: ❑ Sweet ❑ Cold ❑ Hot ❑ Pressure ❑Nothing
Are you happy with the appearance of your smile? ❑ Yes ❑ No
If no, please explain: _____
Are you concerned with any of the following: ❑ Bad Breath (malodor) ❑ Snoring ❑ Sleep Apnea ❑ Grinding Your Teeth (Bruxism)
Are you aware of possible TMJ problems – does your jaw joint make noise or lock up? ❑ Yes ❑ No
Is there anything else that would be valuable for your dentist to know? _____
_____

Medical History

Physician Name: _____
Address: _____ City: _____ State: _____ Zip: _____
When was your last examination? _____

Are you currently under the care of a physician or have you been in the last 5 years including any hospitalizations or surgery? ☐ Yes ☐ No If yes, please explain: _____

_____

_____

Are you taking any medications? ☐ Yes ☐ No Please list your medications and dosages below:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

(Women) Are you pregnant or lactating? ☐ Yes ☐ No How many weeks pregnant?_____

Do you need special accommodations while in our office? _____ please specify_____

Are you allergic/sensitive to any of the following: (check all that apply) ☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ Latex ☐ Aspirin ☐ Seasonal ☐ Sulfa ☐ Vicodin ☐Other (please specify) _____ ☐ No known allergies

Please check any of the following that apply to you:

☐ Anemia	☐ Arthritis	☐ Artificial Joints/Prosthetic Implant	
☐ Asthma	☐ Blood Disease	☐ Blood Transfusions	☐ Cancer
☐ Chemical Dependency	☐ Chemo Therapy	☐ Chest Pain (Angina)	☐ Chew Tobacco
☐ Congenital Heart Defect	☐ Congestive Heart Failure-CHF		☐ Coumadin/Warfarin
☐ Depression	☐ Diabetes Type:_____	☐ Emphysema	☐ Epilepsy/Convulsions
☐ Excessive Bleeding	☐ Fainting/Seizures	☐ Glaucoma	☐ Head Injuries
☐ Hearing Impaired	☐ Heart Attack	☐ Heart Disease	☐ Heart Murmur
☐ Heart Surgery	☐ Heart valve replacement		☐ Hepatitis B
☐ Hepatitis C	☐ High Blood Pressure	☐ High Cholesterol	☐ HIV
☐ History of Sedation/Anesthesia Problems		☐ History (Family) of Sedation/Anesthesia Problems	
☐ Jaundice	☐ Kidney Disease	☐ Leukemia	☐ Liver Disease
☐ Lung Disease	☐ Mental Disorders	☐ Mit Valve Prolapse	☐ Nervous Disorders
☐ Oral Herpetic Lesions	☐ Osteoporosis	☐ Pacemaker	☐ Pre-Medication for dental treatment
☐ Pregnancy	☐ Pneumonia	☐ Psychiatric Care	☐ Radiation Treatment
☐ Recent Weight Loss/Gain	☐ Recreational Drugs	☐ Respiratory Problems	☐ Rheumatic Fever
☐ Rheumatism	☐ Sinus Problems	☐ Sleep Apnea	☐ Smoke Cigarettes
☐ Snoring	☐ Stroke	☐ Thyroid Problem	☐ Tuberculosis
☐ Tumors	☐ Ulcer/Acid Reflux	☐ Venereal Disease	

Explain:_____

_____

_____

To the best of my knowledge, the forgoing questions have been answered accurately. I will report any changes in my health, illness, hospitalization, or addition in and/or change in medication to those listed.

Patient Signature_____Date _____

Relationship to patient (if not patient completing form) _____