

p d e e p n p t e a s l

everything *in* between.

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain your best oral health.

~ Personal Information ~

Name of Patient _____ Date _____
Male _____ Female _____ Birthdate _____ Social Security # _____ - _____ - _____
Single _____ Married _____ Divorced _____ Widowed _____
Home # _____ - _____ - _____ Cell # _____ - _____ - _____ E-Mail _____
Address _____ City _____ State _____ Zip _____
Employer _____ Work # _____ - _____ - _____ Ext. _____
Occupation _____ How long employed _____

~ Responsible Party ~

Complete if different from above

Name _____ Relationship to Patient _____
Home # _____ - _____ - _____ Social Security # _____ - _____ - _____
Address/City/State/Zip _____

~ Dental Insurance Information ~

Name of Insured _____ Relationship to Patient _____
Insured's Birthdate _____ Social Security # _____ - _____ - _____ Employer _____
Insurance Company _____ Group # _____ Phone # _____

~ Other Information ~

Who may we thank for referring you? _____
In the event of an emergency, who should we contact? _____
Relationship _____ Home # _____ - _____ - _____ Work # _____ - _____ - _____
Reason for visit _____

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Name _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills or drugs? Yes No If yes, please explain: _____
- Are you on a special diet? Yes No _____
- Do you use tobacco? Yes No _____

Women: Are you

- Pregnant/Trying to get pregnant? Nursing?
- Taking oral contraceptives?

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
- Other If yes, please explain: _____

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

- | | | | | |
|---|---|---|---|--|
| <input type="radio"/> AIDS/HIV Positive | <input type="radio"/> Congenital Heart Disorder | <input type="radio"/> Hay Fever | <input type="radio"/> Liver Disease | <input type="radio"/> Stomach/Intestinal Disease |
| <input type="radio"/> Anaphylaxis | <input type="radio"/> Convulsions | <input type="radio"/> Heart Attack/Failure | <input type="radio"/> Low Blood Pressure | <input type="radio"/> Stroke |
| <input type="radio"/> Anemia | <input type="radio"/> Cortisone Medicine | <input type="radio"/> Heart Murmur | <input type="radio"/> Lung Disease | <input type="radio"/> Swelling of Limbs |
| <input type="radio"/> Angina | <input type="radio"/> Diabetes | <input type="radio"/> Heary Pace Maker | <input type="radio"/> Mitral Valve Prolapse | <input type="radio"/> Thyroid Disease |
| <input type="radio"/> Arthritis/Gout | <input type="radio"/> Drug Addiction | <input type="radio"/> Heart Trouble/Disease | <input type="radio"/> Pain in Jaw Joints | <input type="radio"/> Tonsillitis |
| <input type="radio"/> Artificial Heart Valve | <input type="radio"/> Easily Winded | <input type="radio"/> Hemophilia | <input type="radio"/> Parathyroid Disease | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Artificial Joint | <input type="radio"/> Emphysema | <input type="radio"/> Hepatitis A | <input type="radio"/> Psychiatric Care | <input type="radio"/> Tumors or Growths |
| <input type="radio"/> Asthma | <input type="radio"/> Epilepsy or Seizures | <input type="radio"/> Hepatitis B or C | <input type="radio"/> Radiation Treatments | <input type="radio"/> Ulcers |
| <input type="radio"/> Blood Disease | <input type="radio"/> Excessive Bleeding | <input type="radio"/> Herpes | <input type="radio"/> Renal Dialysis | <input type="radio"/> Venereal Disease |
| <input type="radio"/> Breathing Problem | <input type="radio"/> Excessive Thirst | <input type="radio"/> High Blood Pressure | <input type="radio"/> Rheumatic Fever | <input type="radio"/> Yellow Jaundice |
| <input type="radio"/> Bruise Easily | <input type="radio"/> Fainting Spells/Dizziness | <input type="radio"/> Hives or Rash | <input type="radio"/> Rheumatism | |
| <input type="radio"/> Cancer | <input type="radio"/> Frequent Cough | <input type="radio"/> Hypoglycemia | <input type="radio"/> Scarlet Fever | |
| <input type="radio"/> Chemotherapy | <input type="radio"/> Frequent Diarrhea | <input type="radio"/> Irregular Heartbeat | <input type="radio"/> Shingles | |
| <input type="radio"/> Chest Pains | <input type="radio"/> Frequent Headaches | <input type="radio"/> Kidney Problems | <input type="radio"/> Sickle Cell Disease | |
| <input type="radio"/> Cold Sores/Fever Blisters | <input type="radio"/> Genital Herpes | <input type="radio"/> Leukemia | <input type="radio"/> Sinus Trouble | |

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

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~ Dental Health ~

Are your teeth sensitive to:

- YES _____ NO _____ Heat
- YES _____ NO _____ Cold
- YES _____ NO _____ Sweets
- YES _____ NO _____ Biting Pressure
- YES _____ NO _____ Does food constantly get stuck between certain teeth?
- YES _____ NO _____ Do you get frustrated because you always have something to be treated or repaired when you visit the dentist?
- YES _____ NO _____ Are you dissatisfied with the way your teeth look?
For example: color, shape, spaces, etc.
- YES _____ NO _____ Do you have fillings that show in your front teeth that you don't like?
- YES _____ NO _____ Do your gums bleed when you brush your teeth?
- YES _____ NO _____ Do you ever avoid any part of your mouth while brushing?
- YES _____ NO _____ Do you have an unpleasant taste or odor in your mouth?
- YES _____ NO _____ Has the fear of discomfort kept you from regular dentist visits?
- YES _____ NO _____ Are you concerned about the finances required to return your mouth to excellent dental health?

How often do you brush your teeth? _____ How often do you floss? _____

How long since your last *thorough* exam with *full mouth x-rays*? _____

If you could change the appearance of your teeth, what would you do? _____

~ Authorization To Perform Dental Treatment ~

I hereby authorize **Peppes Dental** to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize **Peppes Dental** to prescribe any and all forms of medication and perform any therapy and/or treatment that may be indicated and agreed upon.

I further authorize the release of any information, including the diagnosis and the records of any treatment or examinations rendered, to my insurance company or consulting professionals. I understand that my responsibility of payment for dental services provided in this office for me or my dependent is mine, due payable at the time service is rendered.

Signature of patient or responsible party

Today's Date



everything *in* between.

Peppes Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

(Please Print Name)

(Signature)

(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
 - Communications barriers prohibited obtaining the acknowledgement
 - An emergency situation prevented us from obtaining acknowledgement
 - Other (Please Specify)
-
-

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~ Insurance General Information ~

To avoid misunderstandings regarding dental insurance, we would like our patients to know that all professional services rendered in this office are charged directly to the patient, who is ultimately responsible for payment of any and all fees. If your dental insurance company fails to pay their portion or fails to pay the claim within 90 days, you are responsible for payment of balance due in full for any service rendered.

Our office provides a variety of flexible payment alternatives for the patient portion of the balance due, which makes it affordable to receive quality dental care. Unless alternative financial arrangements are made in advance, payment is due when services are rendered.

~ How We Process Dental Insurance Claims ~

1. When the service is rendered, the estimated patient co-payment is collected.
2. The claim form is sent to the insurance company, along with any x-rays, intra-oral camera photographs or other necessary supplemental documentation.
3. We expect the insurance co-payment to be paid to our office within 30 - 60 days.
4. If the insurance co-payment portion paid to us falls short of our original estimate, a bill for the balance due is created and mailed to the patient.
5. If the insurance co-payment portion is not paid within 90 days, a bill for the total balance due is mailed to the patient.

~ Billing Information ~

Peppes Dental requests that your bill is paid at the time of service, unless other arrangements are made in advance. **CANCELLATION POLICY:** There will be a \$40 charge on missed appointments not cancelled 24 hours in advance.

Signature of patient or responsible party

Today's Date