PINECREST DENTAL

IMPLANTS CLEAR BRACES FAMILY

ALL PATIENT INFORMATION IS KEPT STRICTLY CONFIDENTIAL

Patient Name: _____ Date: _____
Last First MI
Male Female Married Single Child Email Address: _____
Please circle
Social Security #: _____ Date of Birth: _____ DL # _____
Phones -- Home: _____ Cell: _____ Work: _____
Spouse name _____ Is spouse a patient of ours? Y N
Spouse phone number _____ Spouse employer _____
Preferred Method of contact (circle) Cell Home Work
Address: _____
Street Apt #:
_____
City State Zip Code
Employer Name: _____ Employer Ph #: _____
Which payment method do you profer? (circle): * Major Credit Card * Cash * Check * Care Credit 0% Interest Financing *

Insurance Information (if applicable)

Primary Dental Insurance – Who is the insured? **Self Spouse** ID#_____ Group# _____
Insurance Plan name & address _____ Plan phone # _____

Secondary Dental Insurance – Who is the insured? **Self Spouse** ID#_____ Group# _____
Insurance Plan name & address _____ Plan phone # _____

Referral Information

Whom may we thank for referring you to our practice (circle)?
Google Facebook 1-800 Dentist Sign Insurance Phonebook Friend/Relative _____
name relation

HEALTH HISTORY

Physician Name: _____ Phone: _____ Date last seen: _____

- Have you been admitted to a hospital or needed emergency care in the past two years? Yes No
- Please list any medications you are currently taking:

_____
_____

- Please list any food, drug or seasonal allergies:

_____

- Have you ever been diagnosed or treated for any of the following (Circle all that apply)

Heart Problems	Osteoporosis	HIV	AIDS
Pacemaker	Immune System	Thyroid	Cancer/Radiation/Chemotherapy
High Blood Pressure	Diabetes	Psychological Treatment	Joint Replacement
Fainting	Anemia	MRSA	Epilepsy
Heartburn/Acid Reflux	Dry Mouth		

- Any other disease, condition, or problem not listed above? Yes No Explain:

_____

- Do you smoke or chew tobacco? Yes No
- (Women Only) Are you pregnant? Yes No
- Have you taken any osteoporosis/bisphosphonate drugs in the past 10 years ? (ie Fosamax, Actonel, Alendronate)
- Do you have any health problems that need further clarification or are not listed here?

DENTAL HISTORY

- Date of last dental visit: _____ Reason for today's visit_____
- While seated in the dental chair do you prefer: Listening To Music Talking Silence
- Do you brush your teeth daily? (circle) Yes No How may days per week do you floss? _____
- How much soda pop or sports drinks do you consume every week? _____
- Have you ever had any complications following dental treatment? Yes No If so what_____
- Are you having pain or sensitivity at this time? Yes No Explain: _____
- Are you nervous or apprehensive about dental treatment? Yes No
- Are you unhappy with the appearance or color of your teeth? Yes No Explain:_____
- Have you recently whitened your teeth? Yes No
- Have you ever had any of the following? (Circle any that apply)

Periodontal/Gum Treatment	Bleeding/Sore Gums	Food Trapped Between Teeth	Orthodontics/Braces
Extraction Complications	Clinching/Grinding Teeth	Loose/Shifting Teeth	Reaction to local anesthetic
TMD/Clicking Jaw	Sensitivity to Hot/Cold	Facial/Dental Trauma	Dry Mouth

Health Questionnaire Consent & Financial Policy

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that Dr. Williams and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Williams or his staff responsible for any action they may or may not take because of errors or omissions that I may have made in the completion of this form. Since a change of medical condition or medications can affect dental treatment, **I understand the importance of and agree to notify Dr. Williams of any changes at any subsequent appointment**. I authorize Dr. Williams and Pinecrest Dental to perform all general preventative and operative treatment procedures necessary to maintain my oral and dental health including administration of local or topical anesthetics, nitrous oxide, or prescription drugs for pain, infection, or medical condition. You also expressly authorize us, and any other person or entity who provides goods or services to you in connection with this agreement, to contact you by sending text messages or e-mails to any of your telephone numbers or e-mail accounts. Methods of contact may include the use of pre-recorded/artificial voice messages and/or the use of an automatic telephone dialing system, as applicable. You acknowledge and agree that this authorization shall extend to any billing or collection company or companies which may be assigned your account(s) for servicing or collection. I also authorize Pinecrest Dental to send dental appointment reminders via text message and/or email.

All dental services mus be paid for at the time services are rendered. If you have insurance, your portion must be paid for at the time of service, unless financial arrangements are made prior to treatment. Even though you have insurance, **you are personally responsible for payment of dental services whether or not your insurance pays the claim**. This agreement also allows Pinecrest Dental to share my information with third party insurance companies in order to complete claims submission. We will gladly help prepare and submit the insurance forms of patients and will credit any such payments received from your insurance plan to the patient's account. However, **this office cannot render services on the assumption that our charges will be paid in full by any insurance company**. Please allow 48 hours notice for appointment cancellations, broken appointments without notification are subject to a $40 fee.

Terms: Net 30 days. Interest at the rate of 1.5% per month (18% annually), will be charged on all past due balances. In the event the account is delinquent and satisfactory arrangements have not been made for payment, all legal fees, attorney fees, court costs, including charges and collection agency fees of up to 50% of the balance assigned, with our without suit.

_____

Signature of Patient or Legal Guardian Date

_____

(under 18) Legal Guardian Name – Birthdate – SSN Date

DENTAL PHOTOGRAPHS

I, _____, do hereby give consent for Dr. Tyler Williams to take and/or display photograph(s) of my smile, ***specifically my teeth and lips***. The photograph will be used for a record of my dental care, and may be used for educational purposes in lectures, demonstrations to other patients, and professional publications and/or marketing. ***My personal information, name, and identity will be kept strictly confidential.***

Signature:_____ Date: _____
Circle Relation to patient (if minor): Parent Legal Guardian

Please provide an email address if you'd like us to email you a copy of your photos:_____