ARBOR DENTAL GROUP Welcomes You

Date _____

thearbordentalgroup.com

PATIENT INFORMATION

_____ Mr./Dr./Mrs./Miss/Ms.

Last Name First Name Middle Name

Mailing Address: _____

Street City State Zip

Nickname: _____ Birthdate: _____ _ Male _ Female

Spouse: _____ Home Phone: _____ Work Phone: _____

Cellular: _____ Soc. Sec. #: _____ Driver Lic. #: _____

Email: _____ Consent to receive Email reminders _ Yes _ No

Employer: _____ Occupation: _____

Employer Address: _____

Street City State Zip

ACCOUNT INFORMATION (If Different From Above)

_____ Mr./Dr./Mrs./Miss/Ms.

Last Name First Name Middle Name

Mailing Address: _____

Street City State Zip

Nickname: _____ Birthdate: _____ _ Male _ Female

Spouse: _____ Home Phone: _____ Work Phone: _____

Cellular: _____ Soc. Sec. #: _____ Driver Lic. #: _____

Email: _____ Consent to receive Email reminders: _ Yes _ No

Employer: _____ Occupation: _____

Employer Address: _____

Street City State Zip

REFERRAL INFORMATION

Were you referred by one of our patients? _ Yes _ No

If Yes, whom may we thank? _____

If No, how did you find us? _____

CONSENT OF TREATMENT

I do authorize and give consent to the Doctor and his staff to administer treatment, including, but not limited to local anesthesia, analgesia, and other such treatment which may be necessary for the above named patient.

Signature -- Patient or Responsible Party X _____ Date _____

PAYMENT AGREEMENT

I understand that I am responsible for all costs of dental treatment. I authorize payment directly to the dental office of the group insurance benefits otherwise payable to me.

Signature -- Patient or Responsible Party X _____ Date

ARBOR DENTAL GROUP

Date _____

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INSURANCE INFORMATION

Insurance Company #1: _____ Group Policy #: _____

Insurance Co. #1 Address _____

Street City State Zip

Policyholder: _____ Policyholder SS#: _____ Policyholder Birthdate: _____

Policyholder Employer: _____

Policyholder Employer Address: _____

Street City State Zip

Effective Date of Coverage: _____

Who is covered?: _____

Insurance Company #2: _____ Group Policy #: _____

Insurance Co. #2 Address: _____

Street City State Zip

Policyholder: _____ Policyholder SS#: _____ Policyholder Birthdate: _____

Policyholder Employer: _____

Policyholder Employer Address: _____

Street City State Zip

Effective Date of Coverage: _____

Who is covered? _____

FINANCIAL POLICY: We are committed to providing the very best treatment for all your dental needs and servicing you with all you financial needs. The following is a statement of our financial policy which we require you to read and sign prior to any treatment: Full payment is due at the time of treatment; We gladly accept checks, cash, most major credit cards and CARE CREDIT. It is customary for new patients to take care of any fees at the first visit until we are able to obtain insurance benefits. If you have particular financial needs, please discuss with our business administrator prior to any treatment. A service charge of 1.5% and any collection charges are applied to all business accounts over 90 days. There will be duplication charges for dental records.

REGARDING INSURANCE: Dental insurance is a contract between you/employer and your insurance company. The policy is not meant to cover all your dental needs and costs but to make dental care more affordable. Estimated insurance is not guaranteed since insurance companies will not accept responsibility until after a claim has been submitted. As a courtesy, we will process your insurance claim and help to maximize any benefits you may be entitled to through your insurance policy. Once your eligibility has been verified by our office, we will ask you to pay your deductible and any "estimated" portion at the time of treatment. However, the ultimate responsibility for any account balance is yours.

Our practice is committed to providing the best treatment for our patients and we charge what is "usual and customary" for our area. Differences that occur between the fee charged and the benefit paid are due to limitations of your dental benefit contract. We are proud of our reputation of ethical and excellent healthcare. Your recommended treatment plan is based on the accepted standards of care and not on your insurance policy.

SENIOR CITIZEN COURTESY: If you are a private patient and are age 65 and over, we will be happy to offer you a "Senior Courtesy".

Thank you for taking the time to read and understand our financial policy. Please let us know if you have any questions or concerns.

X _____ _____

Signature of Responsible Party Date

DENTAL HISTORY

1. What can The Arbor Dental Group do for you?

2. When was the date of your last dental visit? _____

3. When were your last x-rays taken? _____

4. Name of previous dentist: City / State/ Phone _____

5. Shall we request the records of your previous dentist? __ Yes __ No

6. How would you rate you previous dental experience? Excellent / Good / Average / Poor (circle)

7. Are you happy with your smile? __ Yes __ No

8. Do you want whiter teeth? __ Yes __ No

9. Are you happy with the position of your teeth? __ Yes __ No

10. Do you experience frequent bad breath? __ Yes __ No

11. Do your gums bleed when you brush or floss? __ Yes __ No

12. Do you have loose teeth? __ Yes __ No

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Date: _____

Medical History

Although our Dental Team primarily treats areas in and around your mouth, the health of your entire body can influence treatment you may receive. Certain health conditions or medication can have significant interactions with the dentistry you may receive. Please answer the following questions as accurately as possible. Thank You!

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:	_____
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes ☐ No	If yes, please explain:	_____
Are you on a special diet?	☐ Yes ☐ No	If yes, please explain:	_____
Do you use tobacco?	☐ Yes ☐ No	If yes, please explain:	_____
Do you use controlled substances?	☐ Yes ☐ No	If yes, please explain:	_____

Please list any medications, pills, or drugs you are taking: _____

_____

Women: Are you pregnant or trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

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?

☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Hemophilia	☐ Renal Dialysis	☐ Other Serious Illness
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis A	☐ Rheumatic Fever	Please Explain:_____
☐ Anaphylaxis	☐ Drug Addiction	☐ Hepatitis B or C	☐ Rheumatism	_____
☐ Anemia	☐ Easily Winded	☐ Herpes	☐ Scarlet Fever	_____
☐ Angina	☐ Emphysema	☐ High Blood Pressure	☐ Shingles	_____
☐ Arthritis/Gout	☐ Epilepsy or Seizures	☐ Hives or Rash	☐ Sickle Cell Disease	_____
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hypoglycemia	☐ Sinus Trouble	_____
☐ Artificial Joint	☐ Excessive Thirst	☐ Irregular Heartbeat	☐ Spina Bifida	_____
☐ Asthma	☐ Fainting Spells/Dizziness	☐ Kidney Problems	☐ Stomach Disease	_____
☐ Blood Disease	☐ Frequent Cough	☐ Leukemia	☐ Intestinal Disease	_____
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Liver Disease	☐ Stroke	_____
☐ Breathing Problems	☐ Frequent Headaches	☐ Low Blood Pressure	☐ Swelling of Limbs	_____
☐ Bruise Easily	☐ Genital Herpes	☐ Lung Disease	☐ Thyroid Disease	_____
☐ Cancer	☐ Glaucoma	☐ Mitral Valve Problems	☐ Tonsillitis	_____
☐ Chemotherapy	☐ Hay Fever	☐ Pain in Jaw Joints	☐ Tuberculosis	_____
☐ Chest Pains	☐ Heart Attack/Failure	☐ Parathyroid Disease	☐ Tumors or Growths	_____
☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Psychiatric Care	☐ Ulcers	_____
☐ Congenital Heart Disease	☐ Heart Pace Maker	☐ Radiation Treatments	☐ Venereal Disease	_____
☐ Convulsions	☐ Heart Trouble/Disease	☐ Recent Weight Loss	☐ Yellow Jaundice	_____

Signature

I certify that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or my patient's) health. I will not hold my Dentist or any members of his/her Dental Team responsible for errors or emissions that I have made in completion of this form. It is my responsibility to notify my Dentist of any changes in the above medical status.

Patient or Responsible Party Signature: **X** _____ Date: _____