THE CENTER OF
DENTAL
PROFESSIONALS

Welcome

We want to help you have the brightest smile possible.
Please fill out this form completely so we can know how to best help you reach maximum oral health.
The better we know you, the better we can care for you.

1 you

NAME ☐ MALE ☐ FEMALE

BIRTHDATE / / SS#

STREET ADDRESS

CITY STATE ZIP

E-MAIL ADDRESS

HOME PHONE MOBILE

OFFICE PHONE

EMPLOYER HOW LONG THERE?

EMPLOYER ADDRESS

BEST TIME TO REACH YOU

WHO MAY WE THANK FOR REFERRING YOU?

OTHER FAMILY MEMBERS SEEN BY US

PREVIOUS DENTIST

PHONE # LAST VISIT THERE

2 spouse

SPOUSE NAME

EMPLOYER

WORK PHONE SS#

BIRTHDATE

OTHER PERSON RESPONSIBLE FOR ACCOUNT

RELATIONSHIP

ADDRESS

PHONE SS#

3 insurance

PRIMARY INSURANCE DENTAL COVERAGE? ☐ YES ☐ NO

INSURANCE CO. NAME

ADDRESS

PHONE GROUP #

INSURED NAME RELATION

INSURED BIRTHDATE IINSURED SS#

SECONDARY INSURANCE DENTAL COVERAGE? ☐ YES ☐ NO

INSURANCE CO. NAME

ADDRESS

PHONE GROUP #

INSURED NAME RELATION

INSURED BIRTHDATE IINSURED SS#

4 medical contacts

DO YOU HAVE A PERSONAL PHYSICIAN? ☐ YES ☐ NO

PHYSICIAN NAME

PHONE DATE OF LAST VISIT

ARE YOU UNDER CARE OF THIS DOCTOR NOW?

EXPLAIN?

NEIGHBOR/RELATIVE TO CONTACT IN EMERGENCY:

RELATIONSHIP

HOME PHONE MOBILE

STREET ADDRESS

CITY STATE ZIP

5 medical history

MY CURRENT HEALTH IS ☐ GOOD ☐ FAIR ☐ POOR

HAVE YOU SMOKED OR USED TOBACCO IN ANY OTHER FORM? ☐ YES ☐ NO

HAVE YOU EVER HAD ANY METAL RODS, PINS OR IMPLANTS? ☐ YES ☐ NO

ARE YOU TAKING ANY PRESCRIPTION / OVER-THE-COUNTER OR HERBAL SUPPLEMENT DRUGS?

☐ YES ☐ NO IF YES, PLEASE LIST BELOW

ARE YOU TAKING BIRTH CONTROL PILLS?

ARE YOU PREGNANT?

ARE YOU NURSING?

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

- ☐ ASPIRIN
- ☐ DENTAL ANESTHETICS
- ☐ JEWELRY/METALS
- ☐ PENICILLIN
- ☐ OTHER (PLEASE LIST)
- ☐ CODEINE
- ☐ ERYTHROMYCIN
- ☐ LATEX
- ☐ TETRACYCLIN

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

- ☐ ABNORMAL BLEEDING / HEMOPHILIA
- ☐ AIDS/HIV
- ☐ ALCOHOL / DRUG ABUSE
- ☐ ANEMIA
- ☐ ARTHRITIS
- ☐ ARTIFICIAL BONES / JOINTS / VALVES
- ☐ ASTHMA
- ☐ BLOOD TRANSFUSION
- ☐ CANCER / CHEMOTHERAPY
- ☐ COLITIS
- ☐ CONGENITAL HEART DEFECT
- ☐ DIABETES
- ☐ DIFFICULTY BREATHING
- ☐ EMPHYSEMA
- ☐ EPILEPSY / CONVULSIONS
- ☐ FAINTING SPELLS
- ☐ FREQUENT HEADACHES
- ☐ GLAUCOMA
- ☐ HAY FEVER
- ☐ HEART ATTACK / SURGERY
- ☐ HEART MURMUR
- ☐ HEPATITIS A B C
- ☐ HERPES / FEVER BLISTERS
- ☐ HIGH BLOOD PRESSURE
- ☐ HOSPITALIZED FOR ANY REASON
- ☐ KIDNEY PROBLEMS
- ☐ LIVER DISEASE
- ☐ LOW BLOOD PRESSURE
- ☐ LUPUS
- ☐ MITRAL VALVE PROLAPSE
- ☐ PACEMAKER
- ☐ PSYCHIATRIC PROBLEMS
- ☐ RADIATION TREATMENT
- ☐ RHEUMATIC /SCARLET FEVER
- ☐ SEIZURES
- ☐ SHINGLES
- ☐ SICKLE CELL DISEASE / TRAITS
- ☐ SINUS PROBLEMS
- ☐ STROKE
- ☐ THYROID PROBLEMS
- ☐ TUBERCULOSIS (TB)
- ☐ ULCERS
- ☐ VENEREAL DISEASE

ANYTHING YOU WOULD LIKE TO DISCUSS WITH THE DENTIST IN PRIVATE? ☐ YES ☐ NO

PLEASE LIST ANY OTHER SERIOUS MEDICAL CONDITION(S) THAT YOU HAVE EVER HAD:

6 dental history

WHY HAVE YOU COME TO THE DENTIST TODAY?

HAVE YOU EVER TAKEN PHEN-PHEN? ALSO KNOWN AS REDUX & PONDIMIN? ☐ YES ☐ NO

IF SO, WHEN

DO YOU REQUIRE ANTIBIOTICS BEFORE DENTAL TREATMENT? ☐ YES ☐ NO

ARE YOU CURRENTLY IN PAIN? ☐ YES ☐ NO

HAVE YOU EVER HAD A SERIOUS PROBLEM ASSOCIATED WITH ANY PREVIOUS DENTAL WORK?

☐ YES ☐ NO IF YES, WHAT?

HAVE YOU EVER HAD GUM TREATMENT? ☐ YES ☐ NO

HAVE YOU EXPERIENCED DISCOMFORT IN HIS/HER JAW (TMJ/TMD)? ☐ YES ☐ NO

DO YOUR GUMS EVER BLEED? ☐ YES ☐ NO

HOW MANY TIMES A WEEK DO YOU FLOSS? TIMES A DAY YOU BRUSH?

TYPE OF BRISTLES? ☐ HARD ☐ MEDIUM ☐ SOFT

HOW LONG DO YOU USE A TOOTHBRUSH BEFORE REPLACING IT?

ARE YOUR TEETH SENSITIVE TO HEAT, COLD, OR ANYTHING ELSE? ☐ YES ☐ NO

HAVE YOU LOST ANY TEETH? ☐ YES ☐ NO IF YES, WHY?

DO YOU LIKE YOUR SMILE? ☐ YES ☐ NO

I UNDERSTAND THAT THE INFORMATION THAT I HAVE GIVEN TODAY IS CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT THIS INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.

SIGNATURE DATE / /

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED. IF THIS OFFICE ACCEPTS INSURANCE, I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED AND ALSO RESPONSIBLE FOR PAYING ANY CO-PAYMENT AND DEDUCTIBLES THAT MY INSURANCE DOES NOT COVER. AS PARENT OR GUARDIAN OF THE CHILD RECEIVING TREATMENT, I AM RESPONSIBLE FOR PAYMENT. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTAL OFFICE OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT. I HEREBY AUTHORIZE RELEASE OF ANY INFORMATION, INCLUDING THE DIAGNOSIS AND RECORDS OF TREATMENT OR EXAMINATION RENDERED, TO MY INSURANCE COMPANY.

SIGNATURE DATE / /

THE CENTER OF DENTAL PROFESSIONALS

financial policy

Thank you for choosing our facility as your healthcare provider. We are committed to your treatment being successful.

If you have dental insurance, we will be happy to help you receive your maximum allowable benefits, and we will gladly discuss any insurance options you may have. However, your insurance contract is a contract between you, your employer, and the insurance company. While the filing of claims is a courtesy we extend to our patients, all charges are your responsibility from the date services are rendered.

INSURANCE & INSURANCE COLLECTION

Please understand that insurance reimbursement can be a long and difficult process for our office. In fact, insurers routinely stall, deny, and reduce payments. To that end, our billing staff has undergone extensive and rigorous training to maximize your insurance reimbursement, while reducing the time by which they pay. **Please initial next to your category of insurance listed below,** as this will help us to speed up payment and eliminate confusion in the future. Thank you.

INITIALS **Non-Contracted or Indemnity Insurance Plans**
We may bill your insurance as a courtesy.

INITIALS **Plans in which we are participating providers:**
PPO Plans. We have agreed to accept the discounted rate from your plan, however, all co-insurance is your responsibility. We will estimate balances to the best of our ability. Since the balances are estimates only, we require that you enroll in Quick-Pay to guarantee your account.

INITIALS **Secondary Insurers**
Having more than one insurer DOES NOT necessarily mean that your services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays. We may bill your secondary carrier as a courtesy.

Note: In the event that your insurance does not reimburse us within 45 days, we will simply transfer the balance of your account to your credit, debit, or check card. Please indicate your preference. After your insurance has cleared, you may leave the balance on your card.

PAYMENT OPTIONS

In order to provide you with the highest quality service while keeping our billing costs low, we require paperless billing through Quick-Pay. We simply maintain your credit, debit, or check card number on file to satisfy all co-pays, deductibles, and balances not covered by your insurance. Our Financial Arranger & Coordinator will be more than happy to give you more information about Quick-Pay.

WE ACCEPT ALL MAJOR CREDIT CARDS, DEBIT CARDS, CHECK CARDS AND CASH. WE OFFER THE CARE CREDIT CARD AS OUR EXTENDED PAYMENT OPTION. Ask for details on how to apply.

INITIALS **TRANSFER MY FULL BALANCE TO MY CREDIT CARD ACCOUNT**
(Credit card information required below)

INITIALS **CHARGE MY CREDIT CARD ACCOUNT EQUIVALENT TO THREE (3) MONTHLY PAYMENTS**
(Credit card information required below)

INITIALS **5% DISCOUNT FOR TREATMENT PAID IN FULL PRIOR TO TREATMENT**
(Treatment can be paid for with cash or credit card)

I authorizeThe Center of Dental Professionals to maintain my credit account on file and I assign my insurance benefits to the practice.

PLEASE CIRCLE CARD TYPE:

VISA MasterCard DISCOVER CARD AMERICAN EXPRESS DEBIT VISA CareCredit

ACCOUNT NUMBER EXPIRATION DATE /

SIGNATURE

Billing Fees: In order to provide exceptional care and service to all our patients, we outsource our billing to an independant company, a standard billing fee of $25 will be added to your account if your account exceeds thirty days current.

Divorce Decrees: This office is NOT party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult.

Minor Patients: The adult accompanying a minor and the parents (or guardians) of the minor are responsible for FULL payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/Master card, or payment by cash at the time of service has been verified.

I have read the Financial Policy.
I understand and agree with all terms.

SIGNATURE DATE / /

consent to proceed

I authorize The Center of Dental Professionals providers and/or such associates or assistants as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agents(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventative procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek, or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of the dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and, may in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva, or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

PATIENT NAME

RESPONSIBLE PARTY NAME

RESPONSIBLE PARTY SIGNATURE (patient, legal guardian or authorized agent of patient) DATE / /

WITNESS DATE / /

truth-in-lending statement

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. 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 rendered.
Patients who carry dental insurance understand that all dental services furnished 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 insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding thirty days from the date of service unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. I also understand and agree to a $25.00 returned check fee on all checks returned to this office.

In consideration for the professional dental services rendered to me, or at my request for my minor child or ward, I agree to pay, therefore, the reasonable value of said services to said dentist or his assignee at the time said services are rendered, or within thirty (30) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder to collect monies owed by me, including charges or commissions up to 50% that will be assessed to us by any collection agency retained to pursue this matter.

I authorize assignment or payment of all dental and/or surgical benefits to which I or other family members are entitled, including private dental insurance and other group health plan benefits otherwise payable to the undersigned, The Center of Dental Professionals.

I HEREBY AGREE TO ABIDE BY THE CONDITIONS OUTLINED HEREON.

PATIENT/LEGAL GUARDIAN SIGNATURE

SIGNATURE DATE / /

THE CENTER OF DENTAL PROFESSIONALS

acknowledgment of receipt of privacy policy notice

NAME

STREET ADDRESS DATE / /

CITY STATE ZIP

HOME PHONE ( ) - MOBILE ( ) -

I, ,
acknowledge that I have received a Notice of Privacy Practices from The Center of Dental Professionals.

SIGNATURE DATE / /

If a personal representative is signing this authorization on behalf of the individual, complete the following:

PERSONAL REPRESENTATIVE'S NAME

RELATIONSHIP TO INDIVIDUAL

FOR OFFICE USE ONLY

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

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited us from obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (please specify) _____

patient safety & privacy

For the comfort of the patient, one parent or one accompanying adult are welcome but not required to accompany the child to the operatory. However, for safety and privacy of other patients all others, including children who are not scheduled at this appointment time, are asked to remain in the reception area. Young children in the reception room will need a supervisory adult.

Additionally, the use of cell phones is prohibited in the operatory. The conversations carried on by others present in the clinical area can be distracting to children, which can prevent our providers from having close and careful communication with each young patient.

Thank you for your understanding. Your cooperation in these matters helps us to serve you better.

CANCELLATION POLICY: With considerations to patients that are scheduled after you and to help control office overhead, we have implemented a policy to charge anyone for a failed appointment. A $55.00 charge per appointment will be assessed to anyone failing to arrive for their appointment. Also any appointment(s) cancelled without 48 hours notice given to The Center of Dental Professionals will be subject to the above charge. This is a charge not covered by your insurance company and will be billed automatically to the credit, debit, or check card we have on file. Please be aware that our answering machine does not accept cancellations.

I have read the Patient Safety and Privacy Policy, along with the Cancellation Policy. I understand and agree with all terms.

SIGNATURE DATE / /

personal interest survey

There are a number of ways to evaluate your smile.
Like any other form of art, smile analysis is somewhat objective. What one person loves may look very fake and unnatural to another. The important thing is that you are happy with the way your smile looks so that you feel free to share it with the world. A nice smile can boost confidence and self-esteem, and improve your ability to communicate with others.

Answering the following questions may help determine how satisfied you are with your smile and ways that we can help you find the smile you've always dreamed of.

1. Do you ever feel uncomfortable with the appearance of your smile?

2. Do you ever turn your face or cover your mouth when talking to others?

3. Have you found yourself looking at models or celebrities and wished your smile was like theirs?

4. Do you wish your teeth could be whiter? Straighter? Shorter? Longer?

5. Are you embarrassed to visit a cosmetic dentist because of the condition of your teeth/length of time since your last dental visit?

6. Do you avoid showing a full smile to others, especially strangers?

7. Do photographs of you usually show you smiling with your lips closed to cover your teeth?

8. Have you ever resisted laughing because you are uncomfortable with your smile?

9. Have you thought about those specific things you would like to change about your smile?

10. Are you ready to explore the options available for your smile make-over?

If you answered YES to any of these questions, you may be a good candidate for the exciting transformations available with today's cosmetic dentistry.
We would welcome the opportunity to introduce you to the possibilities for your new smile!

PATIENT NAME _____ DATE ____ / ____ / ____