Payment is due at or before time of service.

Alpine Dental
FAMILY & COSMETIC DENTISTRY

## About You

Name:_____ M F
Last First Mi

Preferred Name:_____ Single Married Other

Birthdate:____/_____/_____ Age:____SSN:_____

Home
Address:_____

_____
City State Zip

Home: ( ) _____ Cell: ( ) _____

Work: ( ) _____

Email:

_____

Employer: _____ Occupation: _____

What is the best time to reach you?

_____

## Additional Information

Previous
Dentist:_____

In the event of an emergency, whom should we contact?

His/Her Name: _____

Home: ( ) _____ Cell: ( ) _____

Work: ( ) _____

## Insurance Information

Insurance Co. Name: _____

Insurance Co. Phone: ( ) _____

Group #: _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____

Insured's ID # or SSN: _____

Secondary Insurance Co. name: _____

## Dental History

Are you allergic to any of the following? Please circle.

| | | |
|---|---|---|
| Aspirin | Dental Anesthetics | Penicillin |
| Codeine | Erythromycin | Sulfa |
| Metals/Plastics | Latex | Other |

List any other drug/material allergies:

_____

Do you require antibiotics before dental treatment? Y N

Are you pregnant? Y _____ N
Due date

What concerns brought you to the dentist today?

_____

Are you currently in pain? Y N

Are your teeth sensitive? Y N

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Y N

Have you ever had a serious/difficult problem associated with any previous dental work? Y N

******APPOINTMENT CANCELLATION POLICY****

**$75 FEE NOTIFICATION**

We reserve the right to charge a minimum of $75.00 per hour in order to cover expenses that may have occurred during the allotted time for your appointment; should you not show up for a schedule appointment or your appointment is cancelled less than 24 hours ahead of your scheduled time here in our office. We confirm 2 days prior as a courtesy ONLY, it is the patient's responsibility to make sure the appointments that are made by you are kept. We thank you for your understanding and cooperation in this matter.

YOUR INITIALS:_____

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## Medical History

Have you ever had any of the following diseases or medical problems? Please circle.

| | | | |
|---|---|---|---|
| Abnormal Bleeding | Difficulty Breathing | Hepatitis | Tuberculosis (TB) |
| Artificial Bones/Joints/Valves | Glaucoma | High / Low Blood Pressure | Ulcers/Colitis |
| Blood Transfusion | Heart Attack/Stroke | HIV / AIDS | Venereal Disease |
| Cancer/Chemotherapy | Heart Murmur | Mitral Valve Prolapse | |
| Congenital Heart Defect | Heart Surgery/Pacemaker | Radiation Treatment | |
| Diabetes | Hemophilia | Rheumatic/Scarlet Fever | |

Any other conditions not listed above: _____

Are you currently under the care of a physician? Y (name of Dr.) _____ N

Are you taking any prescription, over-the-counter drugs or herbal supplements? Y N

Please list:

_____

___ Do you smoke or use tobacco in any form? Y N

I, the undersigned, do hereby acknowledge that I have read, answered to the best of my knowledge, and understood all statements on this document:

- We keep a record of the dental/health care services we provide you. You may ask to see and receive a copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.
- You may see your record or get more information about it by contacting our office.
- I acknowledge availability of a copy of the office Notice of Privacy Practices should I wish to receive one. I understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.
- This office offers Nitrous Oxide (Laughing gas) to our patients for $70. Most insurances do NOT pay for this option and payment is due at time of use.
- This office accepts most insurances but this does NOT guarantee payment of coverage from insurance companies.
- Payment is due at or before time of service.
- I agree to pay interest at the rate of 1% per month (minimum of $1) on my account balance, which remains unpaid 30days, or more after the date I am first billed.
- I understand that I am responsible for payment of services rendered and also responsible for any co-payments and deductibles that my insurance (if any) does not cover.
- This office strives to estimate accurately but I acknowledge that treatment plans are estimated and my final bill will be determined by the final process of my insurance company should I have insurance.
- I understand that I am responsible for all costs of dental treatment. Furthermore, I understand that treatment estimates may change during the actual treatment and signed estimates are just as specified an estimation of the anticipated treatment.
- I hereby authorize any release of information, including diagnosis and records of treatment or examination rendered, to my insurance company. I understand that if I do not pay my bill I will be sent to collections. I agree to pay all costs of collection including a reasonable attorney's fee if this account is referred to a collection agency.

_____

Signature of Patient or Guardian Date