PERSONAL INFORMATION

PATIENT NAME ________________________________ SSN _____________
BIRTHDATE ___________________ MALE/FEMALE (CIRCLE APPROPRIATE SEX)
ADDRESS ____
TELEPHONE: HOME _________________ BUSINESS _____________________
CELL ____________________ OTHER ________________________
OCCUPATION ______________________ EMPLOYER ____________________
SPOUSE NAME _____________________ TELEPHONE ____________________
PERSON TO CONTACT IN EMERGENCY __________________________________
RELATIONSHIP TO PATIENT ___________________ TELEPHONE ___________
PERSON RESPONSIBLE FOR ACCOUNT _________________ SSN _____________
REFERRED BY ____

INSURANCE INFORMATION

IF YOU HAVE DENTAL INSURANCE, AND YOU WISH US TO FILE YOUR INSURANCE COMPANY FOR PAYMENT OF SERVICES RENDERED, YOU WILL NEED TO COMPLETE THE FOLLOWING INFORMATION. PLEASE NOTE THAT DENTAL INSURANCE IS NOT DESIGNED TO COVER ALL FEES.

NAME OF DENTAL INSURANCE COMPANY _______________________________
NAME OF EMPLOYEE'S COMPANY _____________________________________
EMPLOYEE NAME __________________________ EMPLOYEE SSN ___________
EMPLOYEE DATE OF BIRTH ____________ POLICY NUMBER __________________
GROUP NUMBER ______________________

AUTHORIZATION, RELEASE AND AGREEMENT FOR SERVICES RENDERED

I AUTHORIZE DR. SEEKAND AND HER STAFF TO RELEASE ANY INFORMATION, INCLUDING DIAGNOSIS, AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME AND/OR MY FAMILY DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR OTHER HEALTH PRACTITIONERS.

I AUTHORIZE AND HEREBY REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO DR. SEEKAND INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL FEES FOR SERVICES.

I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR ON BEHALF OF MY DEPENDENTS.

I UNDERSTAND THIS RECORD WILL BE IN EFFECT FOR ONE (1) YEAR OR UNTIL I GIVE WRITTEN NOTIFICATION TO CHANGE THE ABOUE.

____ DATE _______________
SIGNATURE OF PATIENT (OR GUARDIAN IF MINOR)

Health History Form

E-mail: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: Last First Middle
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )

Address: Mailing address
City: State: Zip:

Occupation: Height: Weight: Date of birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: ( ) Cell Phone: ( ) *Include area codes*

If you are completing this form for another person, what is your relationship to that person?

Your Name Relationship

Do you have any of the following diseases or problems: ***(Check DK if you Don't Know the answer to the question)***

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information

For the following questions, please mark (X) your responses to the following questions.

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

	Yes	No	DK
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

	Yes	No	DK
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

____

____

____

____

Form Courtesy: © 2007 American Dental Association Form S500

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: ____________ If yes, have you had any complications?____________			
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: ____________			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? ____________			
If yes, how much do you typically drink In a week? ____________			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: ____________			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies - Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics ____________	☐	☐	☐
Aspirin ____________	☐	☐	☐
Penicillin or other antibiotics ____________	☐	☐	☐
Barbiturates, sedatives, or sleeping pills ____________	☐	☐	☐
Sulfa drugs ____________	☐	☐	☐
Codeine or other narcotics ____________	☐	☐	☐
Metals ____________	☐	☐	☐
Latex (rubber) ____________	☐	☐	☐
Iodine ____________	☐	☐	☐
Hay fever/seasonal ____________	☐	☐	☐
Animals ____________	☐	☐	☐
Food ____________	☐	☐	☐
Other ____________	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease.	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: ____________			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus.	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: ____________			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: ____________			
Recurrent Infections	☐	☐	☐
Type of infection: ____________			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation: Phone:

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

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 my dentist and his/her 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 my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

FOR COMPLETION BY DENTIST

Comments: ____________

Seek & Smile
Let's Start Smiling

FINANCIAL POLICY

We strive to provide you and your family with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please feel free to ask if you have any questions about our fees, Financial Policy, or your financial responsibility.

All patients must complete the patient information forms prior to being seen by the doctor, the hygienist, or the dental assistant.

Full payment is due at the time of service unless prior arrangements have been made in writing.

We accept Cash, Checks, VISA, American Express, Discover, and MasterCard for payments.

THERE WILL BE A $25.00 CHARGE FOR ALL RETURNED CHECKS.

Since we operate on an appointment only basis, we do our best to schedule your appointments at a time of your choosing and even call to confirm your scheduled appointment time in advance. **It is important that you inform the office 48 hours in advance if you will not be able to keep your appointment.**
Occasionally we find people that are inconsiderate of their time commitments. *For those few, we reserve the discretion to charge them thirty dollars [$30.00] for their broken and/or missed appointments.*

INSURANCE INFORMATION

Any co-payment and/or deductible required by your insurance company is due at the time of service.

If your insurance company has not paid the FULL BALANCE within thirty (30) days from the date of service, you will have fifteen (15) days to pay the balance in full to avoid any finance charges.

Late Payment Charges of 1.5% per month (18% per year) of the unpaid balance will be added to all accounts after forty-five (45) days from the date of service.

If your insurance company pays **MORE** than the estimated amount, we will issue you a credit to your account or a refund check.

If your insurance company pays **LESS** than our original estimate, we will send you a bill for the unpaid balance that is due.

Please be aware that your insurance company may not cover certain procedures. For example, if you elect to have tooth colored fillings instead of metal fillings placed on certain teeth, your insurance company may select to reimburse based upon the fees for a metal filling. ***The difference of these fees will be your responsibility.***

By Signing below, I acknowledge that I have read and agree to the Financial Policy as stated above.

Responsible Party Signature: __________________________ Date:___________

revised 2016

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, ___________________________, have been given the opportunity to receive a copy of this office's "Notice of Privacy Practices".

Please Print Name

_________________________________ Date ____________

Signature

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.

( ) Communication barriers prohibited obtaining the acknowledgement.

( ) An emergency situation prevented us from obtaining acknowledgement.

( ) Other (Please Specify).

____