Welcome

We would like to welcome you to Caring Way Dentistry. In an effort to provide the best service possible, we ask that you fill out this form as completely as possible.

Patient Name: _____ _____ _____ _____ _____
Last First Middle Sex MaritalStatus

Address: _____ _____ _____ _____
Street City State Zip

Birthdate: _____ **Age:** _____ **Social Security#:** _____ **E-Mail:** _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Employer: _____ **Occupation:** _____

Who may we Thank for referring you to our office? _____

Spouse / Additional Contact Information

Name: _____ **Relationship to Patient:** _____

Address: _____ **E-Mail:** _____

Birthdate: _____ **Employer:** _____ **Occupation:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Dental Insurance Information

Policy Owner's Name: _____ **Policy Owner's Social Security #:** _____

Policy Owners Birthdate: _____ **Relationship to Patient:** _____

Policy Owner's Employer: _____ **Employer's Address:** _____

Insurance Company: _____ **Group / Plan #:** _____

Insurance Company Address: _____ **Ins. Co. Phone:** _____

Secondary Policy

Policy Owner's Name: _____ **Policy Owner's Social Security #:** _____

Policy Owners Birthdate: _____ **Relationship to Patient:** _____

Policy Owner's Employer: _____ **Employer's Address:** _____

Insurance Company: _____ **Group / Plan #:** _____

Insurance Company Address: _____ **Ins. Co. Phone:** _____

Primary Care Doctor: _____ **Phone #:** _____

Previous Dentist: _____ **Last Exam:** _____ **Last Dental X-Rays:** _____

Name:_____ Date of Birth:_____ Age:_____

Dental History

	YES	NO
Bad Breath		
Bleeding or Sore Gums		
Previous Periodontal Tx		
Do you have missing teeth?		
If so would you like to have them replaced?		
Teeth tender when chewing?		
Discomfort in Face, Head or Neck?		
Sensitivity to Sweets?		
Food Caught Between Teeth?		
Interested in Straightening Teeth?		

	YES	NO
Do you Clench/Grind your teeth?		
Recurring sores in or around mouth?		
Jaw Clicking or Popping?		
Sensitivity to Hot or Cold?		
Swelling or Lumps in Mouth?		
Are you a "Mouth Breather"?		
Loose Teeth or Broken fillings?		
Previous Orthodontic Treatment?		
Interested in Whitening your teeth?		
Are you a Soda Drinker?		

Do You Smoke? _____ How Much/Often?_____
When do You Brush? _____
When do You Floss? _____
If so, How Much? _____
On a Scale of 1-10 how would you Rate your Smile? _____
Where would you like it to Rate? _____
In the past, has anything kept you from getting the dental treatment you want and deserve? _____

Medical History

	YES	NO
Acid Reflux / GERD		
Artificial Joints or Implants		
AIDS / HIV		
Allergies – Medical		
Allergies – Seasonal (Hay fever, etc)		
Asthma		
Blood Disorder _____		
Blood Transfusions		
Cancer _____		
Chemo or Radiation		
Chemical Dependency		
Circulatory Problems		
Diabetes		
Emphysema		
Epilepsy, Seizures or Fainting		
Excessive Bleeding		
Glaucoma		
Headaches / Migraines		
Hearing Aid or Disorder		
Heart Problems		

	YES	NO
Heart Murmur		
Hepatitis A, B or C _____		
Herpes		
Blood Pressure High___Low___		
Jaw Pain		
Liver Disease		
Mitral Valve Prolapse		
Nervous Disorder		
Pacemaker		
Pregnant (Due Date_____)		
Rheumatic Fever		
Sinus Problems		
Shortness of Breath		
Stroke (Date _____)		
On Birth Control Pills		
Thyroid Disease Hyper____ Hypo____		
Tuberculosis		
Ulcers, Digestive Problems		

Other, not Mentioned Above _____
Have you Ever Taken Bisphosphonate Drugs? (Fosamax, Boniva, Zometa, Aredia, Actonel) _____
If so, was it in Pill or IV form? _____

Allergies (please circle all that apply) Aspirin Codeine Erythromycin Keflex
Latex Metals Penicillin Sulfa Tetracycline Other_____

Do you Wish to Discuss (please circle all that apply) Oral Sedation Cosmetic Dentistry Acid Reflux

Please List ALL Medication you are currently taking and the correlating disease, include Vitamins, Herbs and Over the Counter Medications: _____

Patient Signature:_____ Date:_____
Guardian Signature (if patient is a minor):_____

OUR FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are fully committed to the successful conclusion of your prescribed dental treatment. Please understand that payment for services rendered is considered an integral part of your treatment. The following is a statement of our Financial Policy which should be read carefully by you and signed prior to any treatment.

FULL PAYMENT IS DUE AT TIME OF SERVICE

WE ACCEPT CASH, CHECK, VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER CARDS

WE OFFER AN EXTENDED CREDIT PLAN WITH PRIOR CREDIT APPROVAL (for some procedures)

Regarding Insurance:

We will verify your insurance coverage upon your arrival in our office. If we are unable to obtain verification of benefits while you are with us, you may be required to pay in full for that visit. It should be recognized that any balance is your responsibility whether your insurance company pays or not. **Your insurance policy is a contract between you and your insurance company;** we are not a party to that contract. In the event we do accept assignment of benefits, we require that you provide a credit card with authorization to bill that account for the balance. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance program.

Usual and Customary Rates:

Our practice is committed to providing the best treatment for all our patients and we charge what is usual and customary for this community. You are responsible for payment regardless of any insurance company's determination of usual and customary rates.

Missed Appointments:

Unless canceled, at least 24 hours in advance, our policy is to charge a fee of $50.00 for missed appointments. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have fully read, understand and hereby agree to this financial policy.

X_____ Date_____

Signature

AUTHORIZATION FOR US TO RELEASE MEDICAL INFORMATION

I hereby authorize Dr. Villescas to release any medical/dental information regarding myself to my physician, insurance company, lawyer or anyone else specifically named by me. This information includes records and/or referring physicians reports or copies thereof.

I have read this statement carefully. I understand it completely and sign without any reservations, not even the slightest doubt.

SIGNATURE_____ **DATE**_____

AUTHOURIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize any physician, hospital, clinic or other medical facility, or any other persons having any records or knowledge of me or my health to give Dr. Villescas any and all information regarding the undersigned or copies thereof which may be to my own dental care.

SIGNATURE_____**DATE**_____