Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help. We look forward to working with you in maintaining your dental health.

Patient Name_____ Social Security Number_____

Spouse's Name_____ Patient Birthday_____

Address_____ City_____

State_____ Zip_____ O Male O Female

Person Responsible for Account_____

Whom may we thank for referring you?_____

Contact Information

Home ( )_____ Work ( )_____ Cell ( )_____

Spouse's Work ( )_____ Email Address_____

Best time and place to reach you_____

How would you like to contacted for appointment reminders? O Phone O Email O Text

Emergency Contact (someone not living with you) Name_____

Home ( )_____ Cell ( )_____ Relationship_____

Dental Insurance

Subscriber's Name _____ Employer_____

Insurance Company_____ Group #_____

Phone ( )_____ Subscriber ID _____Birthdate _____

Secondary Insurance Company

Subscriber's Name_____ Employer_____

Insurance Company_____ Group #_____

Phone ( )_____ Subscriber ID_____ Birthdate_____

Financial Agreement

Thank you for choosing us for your dental care. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. **Regarding Insurance:** If you are covered by insurance and have a pending deductible we require payment in full at time of service. If your deductible is met we require your co-pay to be paid at the time of service. Any other arrangements must be made in advance with office personnel. Customarily insurances only pay a portion of the expenses. We are pleased to assist you in filing insurance claims. However, your insurance policy is a contract between you and your insurance company. Although we may be a participating provider with your plan, we are not a party to your policy contract. Any portion of the fees not covered by insurance remains your responsibility. We appreciate prompt payment. Any accounts having balances older than 60 days will be assessed a monthly service charge of 1.75% (21% annual). **Usual and Customary Charges:** Our practice is committed to providing the most appropriate and best possible treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. **Regarding No Insurance:** As it is customary to pay for professional services at the time of the visit, payment in full is due at time of service. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER. Thank you for considering our financial policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy

Signature_____ Date_____

Medical History

Are you under a physician's care now? O Yes O No
Have you ever been hospitalized or had a major operation? O Yes O No
Have you ever had a serious head or neck injury? O Yes O No
Are you taking any medications, pills, or drugs? O Yes O No If yes, please explain:________________________
Do you take, or have you taken, Phen-Fen or Redux? O Yes O No
Have you ever taken Fosamax, Boniva, Actonel
or any other medications containing bisphosphonates? O Yes O No
Are you on a special diet? O Yes O No
Do you use tobacco? O Yes O No
Do you use controlled substances? O Yes O No

____
____
____

Women: Are you
Pregnant/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 ☐ Local Anesthetics ☐ Latex ☐ Sulfa Drugs ☐ Other

If yes, please explain:____

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problem	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pace Maker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No
						Yellow Jaundice	○ Yes ○ No

Do you have, or have you had any of the following?

Have you ever had any serious illness not listed above? ○ Yes ○ No **If yes, please explain:**
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Comments:_____
_____
_____

Reason for today's visit_____ How often do you floss?_____ Brush?
_____

Have you received dental care in the past six months? ○ Yes ○ No

Have you had any complications following dental treatment? **If yes, please explain:**
_____

Please check any of the following that would describe your ideal dental cleaning:

□ Soft, extremely gentle
□ Comfortable, slightly sensitive
□ Thorough with slight discomfort
□ Uncomfortable but necessary

I have read and/or been offered a copy of the privacy policy for Legacy Dental ○ Yes ○ No

Signature_____ Date_____