Chart #: ________
FOR OFFICE USE ONLY

Patient Information

Patient Name: ______________________________ Date: __________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other __________

Social Security #: ______________ Birth Date: ______________

Phone (Home): __________ (Work): __________ Ext: ____ Best time to call: __________

Mobile Phone # __________ Email Address ______________

Address: ______________________________
Street Apartment #

____
City State Zip Code

Emergency Contact: Name & Phone #

Health Information

Date of Last Dental Visit: __________ Reason for this visit: ______________

Have you ever had any of the following? This is important information! Please carefully check those that apply:

☐ AIDS/HIV
☐ Allergies __________
____
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Sulfur Drug Allergy
☐ OTHER DRUGS:
____
____
☐ Arthritis
☐ Artificial Joints or Heart Valve
☐ Asthma
☐ Blood Disease
☐ Blood Thinners
☐ Cancer
☐ Circulatory Problems
☐ Diabetes
☐ Depression

☐ Epilepsy
☐ Epinephrine
☐ Excessive Bleeding
☐ Fen-Phen, Redux, etc
☐ Glaucoma
☐ Growths or Tumors
☐ Hay Fever/Sinusitis
☐ Head Injuries
☐ Heart Disease/Attack
☐ Heart Murmur/ Irregular Heart Beat
☐ Hepatitis
☐ High Blood Pressure
☐ Immunosuppression
☐ Jaundice
☐ Kidney Disease/Stone
☐ Latex Allergy
☐ Liver Disease
☐ Lung Disease

☐ Mental Disorders
☐ Mitral Valve Prolapse
☐ Nervous Disorders
☐ Osteoporosis
☐ Pacemaker/ Defibrillator
☐ **Pregnancy**
Due date: __________
☐ Previous Bacterial Endocarditis
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism Rheumatoid Arthritis
☐ Seizures
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke

☐ Transplant
☐ Thyroid Disease
☐ Tuberculosis
☐ Ulcers
☐ Venereal Disease

Please List All Current Medications / Herbal Supplements:
____
____
____
____
____
____
____
____
____

- **Have you ever been advised to take antibiotics before dental treatment?** ☐ **Yes** ☐ **No**
If yes, please explain: ______________________________
- **Have you ever had excessive bleeding after extractions or cuts?** ☐ **Yes** ☐ **No**
If yes, please explain: ______________________________
- **Have you ever had a reaction to any drugs or medication?** ☐ **Yes** ☐ **No**
If yes, please list & explain: ______________________________
- **Have you ever had a serious illness or condition?** ☐ **Yes** ☐ **No**
If yes, please explain: ______________________________
- **Have you ever had any complications following dental treatment?** ☐ **Yes** ☐ **No**
If yes, please explain: ______________________________
- **Have you been admitted to a hospital or needed surgery or emergency care during the past two years?**
☐ **Yes** ☐ **No** If yes, please explain: ______________________________
- **Are you now under the care of a physician?** ☐ **Yes** ☐ **No**
If yes, please explain: ______________________________
- Name of Physician: ______________________________ Phone: __________
- **Do you have any health problems that need further clarification?** ☐ **Yes** ☐ **No**
If yes, please explain: ______________________________

DENTAL & ORAL HEALTH HISTORY

- Are your teeth sensitive to hot, cold or sweets? ☐ Yes ☐ No
- Do you have any fever blisters, mouth ulcers or sores on your lips or mouth? ☐ Yes ☐ No
- Are you aware of anyone in your family having tooth loss or gum disease (pyorrhea)? ☐ Yes ☐ No
- Do your gums bleed after brushing; are they often sore or tender? ☐ Yes ☐ No
- Do you have difficulty swallowing, chewing or do you frequently chew on one side only? ☐ Yes ☐ No
- Does food frequently get wedged between your teeth? ☐ Yes ☐ No
- Have you worn braces? ☐ Yes ☐ No
- In general, do dental treatments cause you much concern or worry? ☐ Yes ☐ No
- Do you chew or smoke tobacco in any form? ☐ Yes ☐ No What type?____________ How many times per day?_____
- Are you dissatisfied with the appearance of your teeth and/or smile? ☐ Yes ☐ No
- What type of toothbrush do you use? ☐ Hard ☐ Medium ☐ Soft ☐ Electric
- When do you brush your teeth? Please check all that apply. ☐ Morning ☐ Noon ☐ Night
- How many times per week do you use toothpicks? __________ dental floss? __________
- Are you aware of clenching or grinding your teeth? ☐ Yes ☐ No
- Do you notice popping, clicking or soreness of the jaws or points just in front of the ears? ☐ Yes ☐ No
  Which side? __________________
- Do you ever have frequent headaches, earaches, stiffness or soreness in your neck? ☐ Yes ☐ No
- When was your last dental check-up?__________, dental x-rays?__________, dental cleaning?__________
- Are you having any other specific problems with your teeth, gums, or mouth? ☐ Yes ☐ No
  If yes, please explain:____

PLEASE INQUIRE ABOUT ANY QUESTIONS THAT ARE NOT UNDERSTOOD!

To the best of my knowledge, all of the preceding answers and information provided are true and correct.
If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date: ____________________
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other________________

Name of person or office referring you to our practice:____________________________________

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ______________

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): ______________ (Work): ______________ Ext: ______ Best time to call: ______________

Address: ____
Street Apartment #

____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ______________________ Occupation: ______________________

Address: ____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: ______________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ______________ ID #: ______________ Group #: ______________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ____

Secondary

Name of Insured: ______________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ______________ ID #: ______________ Group #: ______________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and 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 performed.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 patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.
A service charge will be charged on all accounts exceeding 60 days, 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 understand that if my account becomes delinguent it will be placed with Prim and Mendheim LLC. I also agree and consent to the following terms regarding any outstanding balance that I owe:
I will incur interest on the balance due at the rate of 1.5%per month (18%ann); I will be responsible for reasonable collection costs and attorney fees in and costs of court incurred by this office in the collection of the same, whether such balance is satisfied prior to, after initiation of a lawsuit, or after a judgment has been issued in a lawsuit; and lagree and hereby consent that any lawsuit nd/or legal proceeding any outstanding balance and/or debt I owe, and fees and costs thereon, shall be initiated and litigated in the court of appropriate jurisdiction of Houston County, Alabama, and I hereby waive any and all defenses and/or objections to said jurisdiction and waive all rights to claim exemption. I consent to and agree not to claim any and all personal property, homestead, and /or wage exemptions, in particular that certain wage exemption contained in Article X of the State of Alabama Constitution of 1901, that I may be entitled to, whether the said exemption be statutory and/or constitutional in nature, and waive any and all defenses thereto. I further agree that if a cell phone number has been provided I can be contacted regarding my balance on said cell phone. Additionally, if I reside in Florida, I agree to waive my rights to any exemption that would prohibit a wage garnishment should same become necessary to secure payment of any outstanding balance. I also agree that at any time my balance has not been paid as I have agreed herein that my credit history will be investigated and reviewed. By signing below, I consent to the foregoing terms and acknowledge that I have read, or have been provided adequate time to read, the foregoing before signing below.
I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

______________________________ Date: __________ Relationship to Patient: ______________
Signature of patient, parent or guardian

______________________________ Date: __________ Relationship to Patient: ______________
Signature of guarantor of payment/responsible party

Dothan Dental Group
366 Healthwest Dr.
Dothan, AL 36303

Payment Options

PATIENTS WITH NO DENTAL INSURANCE

______ ______Plan A: Payment in full for services at each visit. We accept cash, checks, or bank cards. (MasterCard, Visa, and Discover) A 5% discount on amounts over $500 will be given for payment by check or cash. There is a $30 charge for any returned check.

______ ______Plan B: Long term payments for comprehensive treatment can be arranged. Payments can be for up to 60 months if desired. Please ask front office personnel for more information.

PATIENTS WITH DENTAL INSURANCE

______ ______Plan A: I would like for Dothan Dental Group, PC to accept assignment of my insurance benefits.* I understand and agree that my co-payment is due in full when services are rendered and I will be paying by:

______ check or cash
______ credit card (Visa, MasterCard, or Discover)
______ long-term financing (ask front office personnel for more information)

***Acceptance of insurance assignment by DDG, PC does not absolve the patient of responsibility for payment in full for treatment rendered. The estimate provided by this office, is to be considered a guideline until the final insurance payment is received and the patient's account has been reconciled. This office can make no guarantee of the insurance payment as estimated. ANY FEES NOT PAID BY INSURANCE WITHIN 60 DAYS ARE THE RESPONSIBILITY OF THE PATIENT.**

______ ______ I understand that although DDG, PC does not accept assignment of secondary benefits and that I will be responsible for my co-payment at the time services are rendered, I also understand that DDG, PC will forward to me a check secondary benefits when they are paid.

I have read and agree to, and have initialed the above financial arrangement.

____________________________ ____________________

Patient Signature Date

Please feel free to call for clarification of our stated options.