PINECREST DENTAL

ALL OF YOUR PATIENT INFORMATION IS KEPT STRICTLY CONFIDENTIAL

Patient Name: _____ Date: _____

First MI Last

Male Female Married Single Child Email Address: _____

Please circle

Social Security #: _____ Date of Birth: _____

Phones (circle preferred contact method) Home: _____ Cell: _____ Work: _____

Spouse name _____ Spouse emergency contact number _____

Spouse's Social Security #:_____ Spouse's Date of Birth:_____

Preferred Method of contact (circle) TEXT CALL EMAIL

Address: _____

Street (Apt #) City State ZIP

- **HOW DID YOU HEAR ABOUT OUR OFFICE**? _____
- Date of last dental visit: _____ Reason for today's visit_____
- While receiving dental care, do you prefer: Watching TV Talking Silence
- Do you brush your teeth daily? (circle) Yes No How many days per week do you floss? _____
- How much soda pop or sports drinks do you consume every week? _____
- What can we do to make your visit(s) with us as comfortable as possible? _____

  _____
- Any bad dental experiences that you've experienced? _____
- What goals or outcomes do you have for your teeth? _____
- Have you ever had any complications following dental treatment? Yes No (Explain)_____
- Are you having pain or sensitivity at this time? Yes No Explain: _____
- Are you nervous or apprehensive about dental treatment? Yes No _____
- Are you unhappy with the appearance or color of your teeth? Yes No Explain:_____
- Have you recently whitened your teeth? Yes No
- Do you snore or have sleep apnea?
- Have your snoring or apnea increased in the past 10 years? Explain: _____
- Do you smoke or chew tobacco? Yes No
- Please list any food, drug or seasonal allergies: _____
- Have you taken any osteoporosis/bisphosphonate drugs in the past 10 years ? (ie Fosamax, Actonel, Alendronate)
- Have you ever had or do have any of the following? (Circle any that apply)

Periodontal/Gum Treatment	Bleeding/Sore Gums	Food Trapped Between Teeth	Orthodontics/Braces
Extraction Complications	Clinching/Grinding Teeth	Loose/Shifting Teeth	Reaction to local anesthetic
TMD/Clicking Jaw	Sensitivity to Hot/Cold	Facial/Dental Trauma	Dry Mouth

HEALTH HISTORY

Physician Name: _____ Phone: _____ Date last seen: _____

● Have you been admitted to a hospital or needed emergency care in the past two years? Yes No

● Please list any medications you are currently taking: (write on bottom of 3rd page if you need more room)

_____

_____

● Have you ever been diagnosed or treated for any of the following (Circle all that apply)

Heart Problems	Osteoporosis	HIV	AIDS
Pacemaker	Immune System	Thyroid	Cancer/Radiation/Chemotherapy
High Blood Pressure	Diabetes	Psychological Treatment	Joint Replacement
Fainting	Anemia	MRSA	Epilepsy
Heartburn/Acid Reflux	Dry Mouth		

●(Women Only) Are you pregnant? Yes No

● Do you have any health problems that need further clarification or are not listed here? _____

_____

_____

Insurance Information- If uninsured would you like more info on our in-house membership plan? (circle) Yes No

(If you've already provided a copy of your current dental and/or medical insurance cards, you don't need to complete your insurance information here)

Primary Dental Insurance – Who is the insured? **Self Spouse** ID#_____ Group# _____

Insurance Plan name & address _____ Plan phone # _____

Secondary Dental Insurance – Who is the insured? **Self Spouse** ID#_____ Group# _____

Insurance Plan name & address _____ Plan phone # _____

Which payment method do you prefer? (circle): * Major Credit Card * Cash * Check * Financing Options

DENTAL PHOTOGRAPHS

I do hereby give consent for Dr. Tyler Williams to take and/or display photograph(s) of my smile, ***specifically my teeth and lips***. The photograph will be used for a record of my dental care, and may be used for educational purposes in lectures, demonstrations to other patients, and professional publications and/or marketing. ***My birthday, address, SSN and medical history will be kept strictly confidential.***

_____

Signature of Patient or Legal Guardian Date

Circle relation to patient (if minor):

Parent Legal Guardian

Health Questionnaire Consent & Financial Policy

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 Dr. Williams and his 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 Dr. Williams or his staff responsible for any action they may or may not take because of errors or omissions that I may have made in the completion of this form. Since a change of medical condition or medications can affect dental treatment, **I understand the importance of and agree to notify Dr. Williams of any changes at any subsequent appointment**. I authorize Dr. Williams and Pinecrest Dental to perform all general preventive and operative treatment procedures necessary to maintain my oral and dental health including administration of local or topical anesthetics, nitrous oxide, or prescription drugs for pain, infection, or medical condition. You also expressly authorize us, and any other person or entity who provides goods or services to you in connection with this agreement, to contact you by sending text messages or emails to any of your telephone numbers or e-mail accounts. Methods of contact may include the use of pre-recorded/artificial voice messages and/or the use of an automatic telephone dialing system, as applicable. You acknowledge and agree that this authorization shall extend to any billing or collection company or companies which may be assigned your account(s) for servicing or collection. I also authorize Pinecrest Dental to send dental appointment reminders via text message and/or email.

All dental services must be paid for at the time services are rendered. If you have insurance, your portion must be paid for at the time of service, unless financial arrangements are made prior to treatment. If I elect for a payment plan, I authorize Pinecrest Dental to run a credit report (after receiving an estimate signed and in writing) on my behalf.

This agreement also allows Pinecrest Dental to share my information with third party insurance companies in order to complete claims submission. I authorize Pinecrest Dental to share my first and last name, and photo in promotional welcome emails, newsletters and direct mail (Address, Date of Birth, SSN, medical history etc. *will never be shared* with anyone except for licensed medical and/or dental insurance companies). We will gladly help prepare and submit the insurance forms of patients and will credit any such payments received from your insurance plan to the patient's account. However, **this office cannot render services on the assumption that our charges will be paid in full by any insurance company**. Even though you have insurance, **you are personally responsible for payment of dental services whether or not your insurance pays the claim**.

Terms: Net 30 days. Interest at the rate of 1.5% per month (18% annually), will be charged on all past due balances. In the event the account is delinquent and satisfactory arrangements have not been made for payment, all legal fees, attorney fees, court costs, including charges and collection agency fees of up to 50% of the balance assigned, with or without suit 45 days after non-payment.

Please note: We ask 2 days notice for reservation changes. Broken reservations without 2 days notification are subject to a **$100 fee**.

_____

Signature of Patient or Legal Guardian Date

_____

(If under 18) Legal Guardian Name – Birthdate Date