

Check In:



Final Review:

Although dental professionals primarily treat the area in your mouth, health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following confidential questions.

**Patient Information** Date \_\_\_\_\_

Patient Name \_\_\_\_\_ D.O. B \_\_\_\_\_

Nickname \_\_\_\_\_ Male or Female \_\_\_\_\_ Single / Married / Divorced / Widowed \_\_\_\_\_ SS# \_\_\_\_\_

Your Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Home# \_\_\_\_\_ Cell# \_\_\_\_\_ Work# \_\_\_\_\_

Email \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_

Are You A Student? Yes No Where? \_\_\_\_\_ Full / Part Time \_\_\_\_\_

Who Can We Thank for Referring You? \_\_\_\_\_

**Dental Insurance Information**

Insured's Name \_\_\_\_\_ D.O.B \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Ins Company \_\_\_\_\_ Ins Phone # \_\_\_\_\_ I.D# \_\_\_\_\_

Employer \_\_\_\_\_ Group# \_\_\_\_\_ Insured's SS# \_\_\_\_\_

**Medical Health**

Physician: \_\_\_\_\_ Phone# \_\_\_\_\_ Last Physical Exam \_\_\_\_/\_\_\_\_/\_\_\_\_

General Health: Excellent \_\_\_ Good \_\_\_ Fair \_\_\_ Poor \_\_\_

Have you had any serious illness, operation, complication, been hospitalized in the past 5 years? No Yes, please explain: \_\_\_\_\_

Are You Taking Medications? (If So What?) \_\_\_\_\_

Are You Allergic To: Penicillin \_\_\_ Latex \_\_\_ Local Anesthetics \_\_\_ Codeine \_\_\_ Sulfa \_\_\_ None \_\_\_

Any Other Allergies? \_\_\_\_\_

Do You Have Any Dental Concerns? NO YES: \_\_\_\_\_

**Women:** Are You Pregnant or Think You May Be Pregnant? Yes No Trimester? 1 2 3 Nursing? Yes No

Indicate Which of The Following You Have Had or Have at Present. Circle Yes or No and Circle Options.

Abnormal Bleeding	YES	NO
AIDS/HIV Positive	YES	NO
Alzheimer's/Dementia	YES	NO
Anemia	YES	NO
Arthritis/Rheumatoid	YES	NO
Asthma	YES	NO
Blood Disease	YES	NO
Blood Thinners	YES	NO
Cancer	YES	NO
Chemotherapy	YES	NO
Convulsions/ Seizures	YES	NO
Digestive Disease	YES	NO
Diabetes Type 1 or 2?	YES	NO
Excessive Bleeding	YES	NO
Epilepsy	YES	NO

Head Injuries	YES	NO
Hearing Impaired	YES	NO
Heart Disease	YES	NO
Heart Pacemaker	YES	NO
Heart Stent/Shunt	YES	NO
Heart Valve Replacement	YES	NO
Hepatitis*	YES	NO
*Type: A, B, C, D, E, F, G?		
Herpes	YES	NO
High or Low Blood Pressure	YES	NO
Infective Endocarditis	YES	NO
Kidney Disease	YES	NO
Mitral Valve Prolapse	YES	NO
Multiple Sclerosis	YES	NO
Neck/Back Problems	YES	NO

Nervous Disorders	YES	NO
Osteoporosis	YES	NO
Bisphosphonates *IV/Oral?	YES	NO
Parkinson's Disease	YES	NO
Prosthetic Joints*	YES	NO
*where/when?		
Radiation Treatment	YES	NO
Sinus Problems	YES	NO
Smoke/Chew Tobacco	YES	NO
Sleep Apnea/ CPAP	YES	NO
Steroid Use	YES	NO
Thyroid Disease	YES	NO
Ulcers	YES	NO
Other:		
Other:		

\*For Parents of Minors: By Signing below, you are agreeing to be responsible Guardian for the minor's account and balances.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_

## Your Dental Story

Gums Bleed While Brushing	YES	NO
Problems with Bad Breath	YES	NO
Sensitivity to Hot/Cold	YES	NO
Grind/Clench Teeth	YES	NO
Frequent Headaches	YES	NO
Clicking/Popping When Chewing	YES	NO
Snore	YES	NO

To understand what's going on in my mouth, my preference is:	
	To know / discuss all the details
	To be shown pictures and videos
	To read pamphlets and brochures

<i>When I think about coming to the dentist I feel:</i>	
	<b>Comfortable</b> – I have no anxiety. My past experiences have been pain free.
	<b>Anxious</b> – I make myself come but am somewhat uncomfortable.
	<b>Fearful</b> – I've stayed away because my past experiences have been traumatic & only come when necessary.
	<b>Extremely fearful</b> – I have avoided the dentist for many years to the detriment of my dental health.

**On a scale of 1-10 (10 being the most) how happy are you with your smile?**



I Have A Fear or Concern About:	
	Not Being Numb
	Being Numb
	Needles
	Gagging
	Loss of Control
	Being Scolded
	Made to Feel Ashamed
	Losing My Teeth
	Catching A Disease
	Cost of Treatment
	Sounds of The Dental Drill
	Waiting
	Other:

If I could change something about my smile, it would be:	
	Whiter
	Straighter
	Healthier
	Close spaces
	Do you have a gummy smile?
	Repair chipped teeth
	Replace missing teeth
	Replace crowns that don't match
	Replace old fillings



## Notice to Our Patients

### *Handling of Your Insurance*

So that you can be clear on how our office handles dental insurance, we wanted to share the following information with you:

Our diagnosis and treatment recommendations for you are based on what is best for your oral health and not based on what your dental insurance plan will cover or will not cover. Your benefits are related to the type of plan chosen by you and your employer. We are not a part of this contract. Often these benefits are not structured to cover the total cost of dental treatment. We will work with you and your primary insurance to get you maximum benefits and provide financial arrangements to allow you to receive your care.

As a courtesy, Collins Dental will bill your insurance company. Should a patient have secondary insurance, we will file with the insurance company; however, it is never a guarantee that the insurance company will make a payment.

If we do not hear from your insurance company within 60 days of billing, the balance will become your responsibility and it is to be paid in full. The responsibility will become yours to collect the reimbursement from your insurance company. A finance charge of 1.5 % will incur at 90 days.

My healthcare information may be disclosed to Collins Dental for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

### *Cancellation and Broken Appointment Policy*

When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. We ask that if you must change an appointment, please give us as least **48 BUSINESS HOURS** notice. This courtesy makes it possible to give your reserved room to another patient who would like it. A charge of \$75 will be charged if you do not show up for your scheduled appointment or for repeated cancellations without 48-hour notice.

Repeated cancellations or missed appointments may result in loss of future appointment privileges as well. We feel that our patient's time is valuable.

Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

Our goal is to deliver exceptional care for you and your family in a timely manner, and we appreciate your cooperation by honoring your scheduled appointment times.

Please sign that you have read and understand the above guidelines.

Printed Patient Name \_\_\_\_\_

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

