



## PATIENT INFORMATION

*Welcome to our office! To assist us in serving you, please complete the following confidential forms.  
The information provided is important to your care and dental health.*

Patient's name \_\_\_\_\_ Preferred name \_\_\_\_\_ Birth date \_\_\_\_\_

If minor, parents names \_\_\_\_\_ Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

May we leave a message on your home or cell phone if needed?

Mailing address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse's name \_\_\_\_\_ Spouse's employer \_\_\_\_\_

Email address \_\_\_\_\_

May we send you reminders by text? \_\_\_\_\_

May we send you reminders by email? \_\_\_\_\_

How did you learn about Paragon Dental? \_\_\_\_\_

BILLING, CREDIT, AND INSURANCE INFORMATION:       Not covered by dental insurance

Your Social Security number: \_\_\_\_\_ Dental Insurance Co. \_\_\_\_\_

Group number \_\_\_\_\_ ID# \_\_\_\_\_

Covered by spouse's insurance?  yes       no

Spouse's dental insurance company \_\_\_\_\_ Group number \_\_\_\_\_

Spouse's birthday \_\_\_\_\_ Social Security number \_\_\_\_\_

Secondary Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ ID# \_\_\_\_\_

## MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?  
(Please check any that apply)

- Cancer or tumor, explain: \_\_\_\_\_
- Heart attack or angina, when: \_\_\_\_\_
- Heart murmur, mitral valve prolapse, heart defect
- Rheumatic fever or rheumatic heart disease
- Artificial joint or valve, explain: \_\_\_\_\_
- High or low blood pressure  
Last BP measurement: \_\_\_\_\_
- Pacemaker
- Tuberculosis, COPD, or other lung problems
- Kidney disease
- Hepatitis or other liver disease
- Alcoholism
- Blood transfusion
- Diabetes
- Neurologic condition
- Epilepsy, seizures, or fainting spells
- Emotional condition
- Arthritis
- Herpes or cold sores
- AIDS or HIV positive
- Migraine headaches or frequent headaches
- Anemia or blood disorders
- Abnormal bleeding after extractions, surgery, or trauma
- Hayfever or sinus trouble
- Allergies or hives
- Asthma  
If Yes, last use of albuterol? \_\_\_\_\_

### ALLERGIES

Are you allergic to, or have you reacted adversely to any of the following?

- Latex materials
- Penicillin or other antibiotics
- Local anesthetics ("Novocain")
- Codeine or other narcotics
- Sulfa drugs
- Barbiturates, sedatives, or sleeping pills
- Aspirin
- Other: \_\_\_\_\_

Are you taking any of the following?

- Aspirin
- Anticoagulants (blood thinners)
- Antibiotics or sulfa drugs
- High blood pressure medicine
- Antidepressants or tranquilizers
- Insulin, Orinase, or other diabetes drug
- Nitroglycerin
- Cortisone or other steroids
- Osteoporosis (bone density) medicine
- Please list all meds below

Women:

- May be pregnant  
Expected delivery date: \_\_\_\_\_
- Taking hormones or contraceptives

Do you smoke or use chewing tobacco?  yes  no

**Please list any medication/vitamins/supplements you are taking:** \_\_\_\_\_

**Name of your**

**physician:** \_\_\_\_\_

**Approximate date of last physical exam by your**

**physician.** \_\_\_\_\_

**Phone number of physician in case consult is needed:**

**Do you have any disease, condition, or problem not listed above?** \_\_\_\_\_

Please add anything else you would like us to know about:

\_\_\_\_\_

-

**Signature of patient** (or parent) \_\_\_\_\_ **Date** \_\_\_\_\_

### Dental History

*So that we can better serve you, can you please take a minute to give us some information about your current dental status and your past dental experiences?*

Approximately when was your last dental visit? \_\_\_\_\_

Are you anxious or apprehensive about dental treatment?    **Y**    **N**

Have you thought about or had sedation(Laughing gas, valium, IV, etc.) for dental treatment?    **Y**    **N**

Do you gag easily?    **Y**    **N**

Do you snore?    **Y**    **N**      Have you been diagnosed with sleep apnea?    **Y**    **N**

Have you orthodontic(braces) treatment?    **Y**    **N**

Have you had a periodontal(gum) ‘deeper’ cleaning or surgery?    **Y**    **N**      if **Y**, when? \_\_\_\_\_

Are your teeth sensitive to temperature?    **Y**    **N**      if **Y**, is it:    **Hot**    **Cold**

Do you have pain when chewing?    **Y**    **N**      if **Y**, then where? \_\_\_\_\_

Does your jaw make any noises/clicks on opening or closing?    **Y**    **N**

Do you clench or grind your teeth?    **Y**    **N**

Do you get frequent:    **neck pain**    or    **headaches**    or    **pain around your ears**

Do you have earaches or pain around your ears?    **Y**    **N**

Do you have frequent sinus infections?    **Y**    **N**

Do your gums bleed easily on brushing or flossing?    **Y**    **N**

Do you get ulcers frequently?    **Y**    **N**

How often do you brush? \_\_\_\_\_ Floss? \_\_\_\_\_

What toothpaste do you normally use? \_\_\_\_\_

What type of toothbrush do you use?    **Manual**    **Electric**    **Soft bristles**    **Medium Bristles**

Do you notice chronic bad breath(halitosis)?    **Y**    **N**

Do you notice a chronic bad taste? Y N

Are you satisfied with the appearance of your teeth? Y N

Have you ever had any trauma to your teeth or face? Y N

If Y to trauma, please describe. \_\_\_\_\_

Describe any *concerns/desires* or *likes/dislikes* about your teeth?

\_\_\_\_\_

\_\_\_\_\_



## Financial Agreement

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment.

### Payment options:

1. Cash
2. Check (5% discount for Cash or Check paid in full)
3. Debit Card
4. Credit Card
5. Care Credit

**Patient with insurance:** We are happy to assist you with your insurance. We participate with many PPO plans and will file the claims and collect from them. In exchange for this service, you sign over to Paragon Dental the right to release information needed to file and collect on your claim. The PATIENT is responsible for the ESTIMATED non-covered portion, procedures and/or deductibles at the time of the service. If the insurance company does not pay after 60 days, we will bill you directly for the full balance. You will get refunded once we collect from the insurance company. Please assist us- in a timely manner- if we need you to contact the insurance company for any reason.

**Parents not accompanying their child** to an appointment must make PRIOR arrangements for payment (cash, check or credit card authorization).

**Parents accompanying their children** are financially responsible for payment.

18% annual **interest** is charged for any unpaid balance after 90 days. A \$15 fee is charged for nonpayment.

There is a \$30.00 processing charge for **non-sufficient funds** or returned checks.

**Records** can be viewed at any time. There is a nominal charge for release or copies of records.

Because instruments, chairs, and personnel are reserved exclusively for your appointment, there is a **\$25 - \$50 CHARGE FOR CHANGED OR BROKEN APPOINTMENTS LESS THAN 48 HOURS IN ADVANCE**. For cases over 2 hours, we reserve the right to a 50% retainer to reserve chair time with the dentist.

I, \_\_\_\_\_, agree to these financial terms.

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