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________ Male/Female

If minor, parents names ________________________

Telephone (Home) ______________ (Work) ______________ (Mobile) ______________

Mailing address ____

City ____________________ State _____ Zip ___________

Employer___________________________________ Occupation____

Spouse's name _______________________________ Spouse's employer _______________________________

Email address____

May we send you reminders by text? **Y or N**

May we send you reminders by email? **Y or N**

How did you learn about Paragon Dental?____

May we leave a message confirming appointments ___YES___NO___

<u>BILLING, CREDIT, AND INSURANCE INFORMATION</u>: ❑ Not covered by dental insurance

Your Social Security number: _____________________ Dental Insurance Co._________________

Policy Holder Name ______________________ Policy Holder Employer _____________________

Policy Holder Birthdate ____________________ Policy Holder Social Security number ____________

ID # _____________________ Group number _________________________

Covered by spouse's insurance? ❑ yes ❑ no

Secondary Insurance Co.______________________ Group #____________________ID#___________________

Emergency Contact Name:______________________ Phone Number___________________

NAME________________________

MEDICAL HEALTH HISTORY

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

- ❑ Cancer
- ❑ Heart condition
- ❑ Angina or Heart Attack date:________________
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ High blood pressure What was last reading ______
- ❑ Pacemaker
- ❑ Artificial joint or valve
- ❑ Surgery ___________________________________
- ❑ Tuberculosis or other lung problems(COPD)
- ❑ Asthma
- ❑ Thyroid problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Stroke or 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
- ❑ Sleep Apnea
- ❑ Hayfever or sinus trouble
- ❑ Alcohol use ________ drinks per week _______
- ❑ Chemical dependency _________________________
- ❑ Tobacco use, what kind?______________________

ALLERGIES

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

- ❑ Latex materials
- ❑ Penicillin or other antibiotics. Describe:

  ____
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_________________________________

Are you taking any of the following? (List in space at bottom)

- ❑ Aspirin 81mg or 325mg
- ❑ Anticoagulants (blood thinners)

  ____
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes medication
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine

Are you on a special diet? _______________________

Women:

- ❑ May be pregnant **YES/NO** Due Date: ________
- ❑ Nursing **YES/NO**
- ❑ Taking hormones or contraceptives **YES/NO**

Please explain any of the above checked:

____

Please list any medication/vitamins/supplements you are currently taking:

____

Physician Name: _______________________________ **Date of last visit:** ___________________________________

Physician Address: _______________________________________ **Physician phone number:** ___________________

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

____

AUTHORIZATION AND RELEASE: I have read and answered the above questions to the best of my knowledge.

Signature of patient (or parent) __________________________________ **Date** ________________

Name ___________________________

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**

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

Have you had a periodontal (gum) 'deeper' cleaning or surgery? **Y** **N** if **YES**, when?_______________

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

Do you have pain when chewing? **Y** **N** if **YES**, 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? **Y** **N**

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

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

Do you chew gum frequently? **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,** describe.____________________

Do you have any *concerns/desires* or *likes/dislikes* about your teeth?

____

____

Name________________________________

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 accordingly. 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 ADVANCE NOTICE**. 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___________