We would like to get to know you better!

DATE:____________________________

I. Patient Information:

Title: Miss☐ Ms.☐ Mrs.☐ Mr.☐ Dr.☐ Other________

Name:____ ________________________

Last name, First, Middle Initial — Preferred Name

SSN____**Date of Birth**_____________________

Address____**Home Phone**_____________________

City____________________________________**State**________________**Zipcode**______________

E-mail address______________________**Cell phone**__________________ **Fax**______________

Employer____ **Occupation**_________________

Address____ **Phone**_____________________

City____________________________________**State**________________**Zipcode**______________

How did you hear about our office?____

Whom may we thank for referring you?____

II. The person financially responsible for this account:

Name____ **Phone**_________________________

Cellphone_____________________

Relationship to patient______________________________ **SSN**__________________________

Address____

City____________________________________**State**________________**Zipcode**______________

Employer____ **Phone**______________________

Address____

City____________________________________**State**________________**Zipcode**______________

III. How will you be paying for services today? Cash☐ Check☐ Credit Card☐ Debit/Most Card☐

Drivers License #_______________________________________ **State**______________________

IV. In case of emergency, who should we notify outside of household:

Name____________________________________ **Relationship**_________ **Phone**______________

Address____

City____________________________________**State**________________**Zipcode**______________

V. Do you have dental insurance? Yes☐ No☐

Name of Carrier____________________________**Phone**_____________________________________

Subscribers Name____

Insured's ID/SSN_________________________________ **Group Number**____________________

VI. Dental information release consent:

I authorize release of any information necessary to process this claim__________________________

VII. Financial policy:

It is the policy of this office to receive payment in full before services are rendered. There are no exceptions unless arrangements are made prior to treatment. We accept CASH, CHECKS (with identification), CREDIT CARDS AND DEBIT/MOST CARD.

Important information:

1. **For those patients who are undergoing extended treatments and/or prosthetic (onlays, crowns, bridges, dentures) procedures financial arrangements will be discussed prior to initiation of treatment, and payment will be due prior to delivery and completing treatment.**
2. **Interest at 1.5% per month will be charged on any unpaid balances over 30 days.**
3. **There will be a $40.00 handling fee for RETURNED CHECKS.**
4. **Your appointment is time that has been *reserved especially for you.***

If you need to change your appointment, we require 48 hours or more to avoid a charge of $50.00 per half hour for the broken appointment of reserved chair time. Subsequent appointments require payment of the broken appointment fee and prepayment for planned treatment.

I have read and agree to the financial policy above. I understand that I am financially responsible for services rendered.

I also understand that as treatment progresses the fees presented may have to be adjusted, but I will be informed of these adjustments and how they will affect my payment plan. Should it become necessary to refer my account to collections, I agree to pay all costs of collections, including, but not limited to, court costs and attorney fees.

____ Date_________________

Signature: (Patient/Guardian if patient is a minor)

VII. Photo release:

I hereby give Faulk Dental Associates the absolute right and permission to use my photographs/slides for educational or promotional purposes. The undersigned completely and forever releases any right to present and future compensation in connection with the use of said photographs/slides.

____ Date_________________

Signature: (Patient/Guardian if patient is a minor)

Dental History

1. What prompted you to seek dental care at this time?______________________________
2. When was your last dental appointment?______________________________
3. What did you have done?______________________________
4. How long since your last *thorough* examinations with *full mouth x-rays*?____________

5. Are your teeth sensitive to:

	YES	NO
Heat	☐	☐
Cold	☐	☐
Sweets	☐	☐
Biting Pressure	☐	☐

6. Have you noticed:

	YES	NO
Swelling	☐	☐
Growths or sore spots in your mouth	☐	☐
Toothaches	☐	☐
Unpleasant taste or odor in your mouth	☐	☐
Bleeding gums when brushing	☐	☐
Constantly getting food stuck between teeth	☐	☐

7. Have you ever had:

	YES	NO
Anesthesia (novocaine, lidocaine etc.)	☐	☐
Allergic reaction to anesthesia	☐	☐
Teeth Removed	☐	☐
Excessive or prolonged bleeding after tooth removal	☐	☐
Serious problems associated with previous dental treatment	☐	☐

8. Do you:

	YES	NO
Avoid any part of the mouth while chewing or brushing your teeth	☐	☐
Have unattractive fillings that show when you smile	☐	☐
Floss Daily	☐	☐
Frequently snack between meals on sweets or chew gum	☐	☐

	YES	NO
9. Has the fear of discomfort kept you from regular dental visits?	☐	☐
10. Would you prefer sedation-Nitrous Oxide (laughing gas)?	☐	☐

Tell Us About You

1. Have you ever had a favorite dentist?______________________________
2. What are your feelings about previous dental care?______________________________
3 What are you looking for in a new dentist or what are your expectations?____________
4. What is most important to you about your dental health?______________________
   Why?______________________________
5. Are you happy with the appearance of your smile?__________
6. If there were no barriers, what would you do to change your smile or teeth?____________
7. Do you wish your teeth could be whiter?____ / Would you be interested in an inexpensive way to whiten them?_____
8. What is the key to retaining you as a long term patient in this practice?____________

Office Use Only

Dentist Review ____________	Date ____________	Dentist Review ____________	Date ____________
Dentist Review ____________	Date ____________	Dentist Review ____________	Date ____________