We value our patients and are committed to providing the highest quality of services. Thank you for choosing our office for your dental care.

PATIENT INFORMATION

Name_____________________________, ____________________________ _________ Sex______ Marital Status __________
Last name First name Middle Initial M or F

Birthdate____-____-_____ Age____ Soc. Sec. # ______-______-______ If child, guardian's name________________________

Address____ City_______________ State________ Zip _____________

Home Phone _________________________ Work Phone _________________________ Cell ________________________________

Email address_____________________________________ Who may we thank for referring you?___________________________

Employer________________________________ Occupation________________________________ Phone______________________

Employer Address______________________________________City___________________State________Zip_________________

PRIMARY DENTAL INSURANCE

Name of Insured___________________________________ Birth date_____________ Relationship to patient__________________

Address (if different from patient) ____

Dental Insurance Company____ Phone ____________________________________

Soc. Sec. # ________________________________ Subscriber ID # ___________________________ Group # __________________

INSURANCE AUTHORIZATION AND OFFICE POLICIES

In order to meet the need of our patients, we have enrolled in various insurance programs. As you can imagine, keeping up with all of the individual requirements for each of the insurance companies can be practically impossible. Each program may have different requirements or stipulations that dictate which services can be provided and how often they can be provided. It is possible that your insurance provider may NOT cover every service we provide in our office, and in these cases, we will have no choice but to bill you for the services provided. It is not our sole responsibility to know every detail of your particular insurance policy, but if we work together, both doing our parts to familiarize ourselves with your specific policy, we can focus on what we do best, take care of you.

- I hereby authorize my insurance company or any other third party payer to pay directly to Christina Boesch, DMD, P.A. all charges submitted for services incurred by me. I authorize use of this signature for all insurance submissions.
- I accept responsibility for payment of dental services and understand that payment for these services, including deductibles and co-payments are due the day services are rendered.
- I understand that my insurance company may disallow and not pay fees related to certain procedures and services that I may receive at this office. I understand that I am responsible for payment and authorize this office to charge my credit card or bank account for any unpaid balances.
- I understand and agree that I am responsible for payment of all charges on my account. If my insurance company fails to pay within sixty (60) days, I will be responsible for the full amount due.
- I understand and agree that insurance benefit information presented is not a guarantee of payment by my insurance company. Therefore, I am responsible for any remaining outstanding balance after my insurance carrier has made payment or processed my claim.
- I understand and agree that if collection action is to be taken to collect payment from me, I will be responsible for all if the costs of such action (collection agency and attorney's fees included).
- I understand that canceling an appointment under 48 hours notice, being late or missing an appointment, or rescheduling the same day as an appointment will result in a broken appointment fee of at least $50.
- I have had a chance to review this office's Notice of Privacy Practices.

I understand and agree to the above stated office policies. ________________________________ _____________
Signature of Patient, Parent or Guardian *Date*

Copayments

To accept insurance, we now debit copayments automatically to your credit card or bank account. If you would like us to accept your insurance, please provide credit card information.

☐ MC Name on Account______________________________ Account # ____________________________

☐ Visa Expiration Date_______________________________ CVC_______Billing Zip Code _____________________

Dental History

Reason for seeking care today: ____Exam ____ Cleaning ____ Specific Problem _________________________________

Date of last dental visit _________________________ Reason for leaving prior dentist? ___________________________

Please check all that apply:

Bad breath	Jaw popping/clicking	Sensitivity to sweets	Changes in bite
Bleeding gums	Grinding teeth	Sensitivity to hot	Food traps
Gums hurt	Clenching teeth	Sensitivity to cold	Loose teeth
Periodontal disease	Headaches	Sores in mouth	Lock jaw

Is there anything that bothers you about the appearance of your teeth or smile? _______________________________________

Have you ever had a bad experience at the dentist? Please explain.____

IS THERE ANYTHING THAT WE CAN DO TO MAKE YOUR DENTAL VISITS MORE COMFORTABLE?___________________

____

In Case of Emergency

Primary Care Physician's name________________________________ Phone ___________________ Fax ___________________

Someone we may contact (relative/friend) ________________________________ Phone ____________________

Medical History

Are you taking any **medications or drugs** (including nutritional supplements?) **Yes** or **No** Please list:

Medication	*What for?*	*Medication*	*What for?*
______________________	______________________	______________________	______________________
______________________	______________________	______________________	______________________
______________________	______________________	______________________	______________________

Are you allergic to any of the following (please circle):

Latex *Penicillin* *Codeine* *Sulfa* *Aspirin* *Metal (nickel earrings)* *Acrylic* *Local Anesthesia* *Medications*

Please specify___________________________________ Other allergies?________________________________

Pregnant? **Yes** or **No** Due date _________________ Are you nursing? **Yes** or **No**

Do you smoke? **Yes** or **No** If you smoke, how much per day?____________________________

HAVE YOU EVER HAD OR HAVE THE FOLLOWING, please circle Y (yes) or N (no):

Artificial Heart Valve …..Y N	Epilipsy……………...Y N	Kidney Disease………Y N	Rheumatic fever……….Y N
Artificial joints …………..Y N	Fainting……………..…Y N	Liver Disease…………Y N	Scarlett fever…………..Y N
Asthma ………………….Y N	Heart Murmur……….Y N	Mitral Valve Prolapse..Y N	Stroke…………………..Y N
Blood disease …………..Y N	Heart Problems……..Y N	Pacemaker……………Y N	Thyroid problem……...Y N
Cancer/Chemotherapy…Y N	Hepatitis……………..Y N	Radiation treatment….Y N	Tuberculosis…………...Y N
Chemical Dependency…Y N	High Blood Pressure Y N	Respiratory disease….Y N	Venereal disease……...Y N
Diabetes ………………...Y N	HIV/AIDS……………Y N	Tobacco habit………..Y N	

Have you ever had surgery or been hospitalized? **Yes** or **No** ____

Have you ever been told that you need to pre-medicate for dental visits? **Yes** or **No** Why?__________________________

Any other illnesses not listed above ____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my (patient's) health. I will inform this office of any changes in my health status.

Patient Signature **(parent or guardian)** ________________________________ **Date** ___________

____________	________
Doctor's signature	Date