Patient Information

Patient Name: _____ Birth Date: _____
Last, First MI (Preferred Named)

Social Security #_____ Gender: _____ Family Status: _____

Phone (Home):_____ (Work): _____ Ext: _____ Cell Phone: _____

E Mail Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

*Are you 65 years of age or older?_____ If so do you qualify for Medicare? _____
(*Because we are not contracted with Medicare, all patients participate in private payment agreements.)

Responsible Party Information

Name: _____ Relation to patient: _____
Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last, First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address:_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last, First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Dental Information and Health History

Date of Last Dental Visit:	Previous dentist:	Last x-rays taken:	Date of Birth:

Reason for this visit:		
Do you have any health conditions (*i.e: heart murmur, artificial joints, etc.*) that require ***antibiotic pre-medication*** prior to dental treatment? Please explain.		
Do you have any drug allergies?	☐ Yes	☐ No
Please list:		
Allergies to Metals, latex, or rubber dam?	☐ Yes	☐ No
Other allergies:		
Are you now under the care of a physician?	☐ Yes	☐ No
Physician Name: Phone:		
Are you taking blood thinners or aspirin on a daily basis?	☐ Yes	☐ No
List all medications currently taking:		
Are you apprehensive about dental treatment?	☐ Yes	☐ No
Have you ever had any complications following dental treatment?	☐ Yes	☐ No
Have you had a bad experience with previous dental treatment?	☐ Yes	☐ No
Please explain:		
Do you gag easily?	☐ Yes	☐ No
Do you wear dentures or partials?	☐ Yes	☐ No
Does food catch between your teeth?	☐ Yes	☐ No
Do your gums bleed easily?	☐ Yes	☐ No
Do your gums feel swollen or tender?	☐ Yes	☐ No
Are your teeth sensitive?	☐ Yes	☐ No
Do you have sensitivity to: ☐ Heat ☐ Cold ☐ Sweets ☐ Biting		
Do you clench or grind your jaws frequently?	☐ Yes	☐ No
Do you have any jaw soreness or headaches		
upon awakening in the morning?	☐ Yes	☐ No
Do you have a temporomandibular (jaw) disorder (TMD)? (Pain in ears or jaw?)	☐ Yes	☐ No
Are you a habitual gum chewer?	☐ Yes	☐ No
History of smoking or tobacco use?	☐ Yes	☐ No
Daily intake For how long Quit how long ago?		
History of alcohol or drug abuse?	☐ Yes	☐ No
Are you happy with the color of your teeth?	☐ Yes	☐ No
Do you prefer to save your teeth?	☐ Yes	☐ No
Women only:		
Are you pregnant	☐ Yes	☐ No Due Date:
Nursing	☐ Yes	☐ No
Taking Birth Control Pills or other hormones	☐ Yes	☐ No

Have you ever had any of the following? Please check those that apply:

☐ Anemia	☐ Epilepsy	☐ Heart Murmur	☐ Nervous Disorders	☐ Stroke
☐ Arthritis	☐ Excessive Bleeding	☐ Hepatitis	☐ Pacemaker	☐ Tuberculosis
☐ Artificial Joints	☐ Fainting	☐ High Blood Pressure	☐ Radiation Therapy	☐ Tumors
☐ Asthma	☐ Glaucoma	☐ HIV	☐ Respiratory Problems	☐ Ulcers
☐ Blood Disease	☐ Growths	☐ Jaundice	☐ Rheumatic Fever	☐ Venereal Disease
☐ Cancer	☐ Hay Fever	☐ Kidney Disease	☐ Rheumatism	☐ Wear contact lenses
☐ Diabetes	☐ Head Injuries	☐ Liver Disease	☐ Sinus Problems	☐ _____
☐ Dizziness	☐ Heart Disease	☐ Mental Disorders	☐ Stomach Problems	☐ _____

• Do you have any health problems that need further clarification?

Please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____

Signature of patient, parent or guardian Date

Consent for Services

Photograph consent:

Chaffin Dental Care provides the highest caliber of services to its patients. Because of the technology and educations we provide, we utilize many types of teaching tools during your dental treatment. Occasionally, we may photograph stages of your dental care. These services provide permanent record and documentation. We also utilize these tools for study club presentations, website and other media representation, and/or marketing and educational forums, etc.

I, _____hereby give Chaffin Dental Care the absolute and irrevocable right and permission, with respect to the photographs that have been taken of my teeth to be used and republished for any commercial use for the territory of the whole world.

-----To copyright the same in its own name or any other name that Chaffin Dental Care may choose.
-----To use, re-use, publish and republish the same in whole or in part, individually or in conjunction with other photographs, in any medium and for any purpose whatsoever, including (but not by the way of limitation) illustration, promotion and advertising and trade through December 31, 2099.

This authorization and release shall also apply to the benefit of the representatives, licensees and assigns of Chaffin Dental Care.

Financial consent and responsibility:

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can *only be extended* for a period of six months from the date of the patient examination. I also understand that there may be changes in dental needs throughout the course of treatment.

Appointment responsibility/re-scheduling:

I understand the value of reserved appointment time, and will give Chaffin Dental Care a minimum of 48 hours for all necessary appointment changes. This will allow other patients to utilize the reserved-time. Failure to attend appointments will result in a $30 fee, which I understand is my responsibility, before making future appointments.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Referral Information

Who may we thank for referring you to our office? _____

☐ Dental Office ☐Yellow Pages ☐Newspaper ☐School ☐Work ☐Other_____

Name of person or office referring you to our practice:_____