GREEN DENTISTRY
LEANDER

New Patient Form

PATIENT INFORMATION

Name: _____
Last First Middle

E-mail address: _____ Gender: _____ _____
Male Female

Cell phone: ( ) _____ Work phone: ( ) _____

Home address: _____
Street City State Zip

Date of birth: __/__/____ Social Security Number: ___–___–____ Driver's License or ID number: _____
MM/DD/YYYY

RESPONSIBLE PARTY INFORMATION (If Patient is a Dependent)

Name: _____
Last First Middle

Relationship to patient _____ E-mail address: _____

Cell phone: ( ) _____ Work phone: ( ) _____

Home address: _____
Street City State Zip

Date of birth: __/__/____ Social Security Number: ___–___–____ Driver's License or ID number: _____
MM/DD/YYYY

DENTAL INSURANCE INFORMATION (Please Provide a Copy of Your Card)

Name of Primary Policy Holder: _____
Last First Middle

Primary policy holder's date of birth: __/__/____ Primary policy holder's SS/ member ID number: ___–___–____
MM/DD/YYYY

Primary Policy Holder's Employer: _____ Rank: _____

Insurance company name: _____ Group number: _____ Insurance company phone: ( ) _____

Insurance company address: _____
Street City State Zip

EMERGENCY CONTACT INFORMATION

Local friend or relative not living with you: _____ Emergency contact phone: ( ) _____

Emergency contact address: _____
Street City State Zip

GETTING TO KNOW YOU

Why did you select our office? _____ Whom May we thank for referring you? _____

When was your last dental visit? _____

When was the last time you had complete dental x-rays taken? _____ Have you ever has any teeth removed? _____

How long have these teeth been missing? _____

How have these teeth been replaced? ☐ Bridge ☐ Partial ☐ Denture ☐ Implants ☐ They have not been replaced

FOR ALL PATIENTS

I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above, and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

_____

Signature of responsible party Relationship to patient Date

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HEALTH HISTORY

Name: _____ Date: _____

Date of birth: _____ Height _____ Weight _____ Age _____ Gender ☐ M ☐ F

Please list all medical problems you are currently being treated for: _____

Please list all of your previous surgeries: _____

Please list any drug, food or latex allergies: _____

Please list your current medications: including aspirin or any other over the counter medications: _____

E-mail address: _____ Gender: _____ _____

Male Female

Cell phone: (_____) _____ Work phone: (_____) _____

Home address: _____

Street City State Zip

DO YOU HAVE, OR HAVE YOU EVER HAD...

☐ Yes ☐ No	Chest Pain	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	Bleeding/blood clot problems
☐ Yes ☐ No	Heart Atteck	☐ Yes ☐ No	Tobacco use	☐ Yes ☐ No	Anesthetic problems
☐ Yes ☐ No	Irregular heart beat	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Epilepsy/seizures
☐ Yes ☐ No	Pacemaker/defibrillator	☐ Yes ☐ No	Liver disease	☐ Yes ☐ No	Galucoma/eye problems
☐ Yes ☐ No	Heart murmur	☐ Yes ☐ No	Kidney disease	☐ Yes ☐ No	Ulcers/gastric reflux
☐ Yes ☐ No	Angioplasty/bypass	☐ Yes ☐ No	Thyroid disease	☐ Yes ☐ No	History of alcohol or drug abuse
☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No	rheumatic fever	☐ Yes ☐ No	Currently pregnant/nursing
☐ Yes ☐ No	Heart valve replacement	☐ Yes ☐ No	Immune system problems	☐ Yes ☐ No	Hip/knee/joint replacement
☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Hepatitis/jaundice	☐ Yes ☐ No	Blood thinners
☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Bone density medication
☐ Yes ☐ No	Emphysema/COPD	☐ Yes ☐ No	Chemotherapy	☐ Yes ☐ No	Require antibiotics prior to surgery
☐ Yes ☐ No	Sleep apnea	☐ Yes ☐ No	Radiation therapy		

DENTAL HISTORY (PLEASE CHECK ALL THAT APPLY)

☐ Routine care only	☐ Orthodontics	☐ Jaw/tooth trauma	☐ TMJ problems	☐ Jaw surgery
☐ Gum disease	☐ Cancer	☐ Mouth sores	☐ Dental implants	☐ Dentures

Please list anything else about your medical or dental history we should know: _____

_____ _____

Signature – Patient/Guardian Doctor's initials

Updated: _____ Date: _____

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DENTAL INSURANCE POLICY

Green Dentistry proudly excepts most dental insurance plans. We file all the dental insurance claims as a patient courtesy. In the event of a treatment plan, we create a reasonable estimate of patient, co-payments and insurance contributions. This estimate is based on contract and insurance rates, the general breakdown of benefits obtained through insurance verification process and our knowledge of common insurance exclusions. **This estimate is not a guarantee of insurance payment. All benefit determinations are at the discretion of the insurance company and are not determined until after a claim is submitted**. We provide treatment estimates as a courtesy in order to minimize the total out-of-pocket cost due by patient. **All estimated patient co-payments are due on or before time of service**.

Patient is responsible for any remaining account balance resulting from insurance nonpayment or underpayment. A statement will be mailed to you regarding this balance. Payment is due immediately upon receipt.

PATIENT ACKNOWLEDGMENT AND AUTHORIZATION

I understand and agree to the Dental Insurance Policy stated above. I authorize all . my insurance companies to make payment directly to Blooming Dental. This assignment will remain in effect unless revoked by me in writing. I understand I am financially responsible for all charges whether or not paid by said insurance company. Further, I authorize the release of any patient information necessary to process these claims.

Signature _____ Date _____

APPOINTMENT DEPOSIT REQUIREMENT

Green Dentistry requires a minimum $50.00 deposit for all appointments requiring 90 minutes or more of estimated chair-time and for all appointments with a total treatment cost of $500.00 or more. The deposit operates as a credit on the patient account towards the total patient portion due on or before time of service. Green Dentistry requires this deposit because our providers and dental assistants reserve the appointment time specifically for you at the excursion of other patients. **The deposit requirement is subject our Cancellation Policy.**

The deposit requirement is reserved only for those patients choosing not to pre-pay for their services in full when scheduling the appointment.

I understand and agree.

Signature _____ Date _____

CANCELLATION POLICY

Green Dentistry makes an effort to see patients on time in order to give patients the care they deserve. Therefore, we ask that you **please give 48 hours notice if you are unable to keep your scheduled appointment. We reserve the right to charge a cancellation fee of $50.00 in the event of two (2) or more missed appointments lacking proper notice**. We will make exceptions in the event of reasonable emergencies.

I understand and agree.

Signature _____ Date _____

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICES

I, _____ , have had the opportunity to review Green Dentistry's Notice of Privacy Practices (the entire legal notice is displayed at the front desk).

Signature _____ Date _____

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Our goal is to provide you with the utmost comfortable and personalized experience during your visit. Please spare a few moments and fill out this profile so we can be of service to you as best as possible.

1. Please rank the following statements from 1~4 regarding what is most important to you in dental care (with 1 being the most important)

   _____ Long-term preventative care (I have healthy teeth and want to maintain them that way)

   _____ Creating a comprehensive dental care plan (I want to invest in my oral health and appearances)

   _____ Dental care is budget driven. (I need to financially plan for any treatment beyond my immediate necessities).

   _____ Other Goals: _____.

2. On a scale of 1 to 10, please indicate how important it is for you to keep your teeth for a lifetime. (10 being very important)

   1 2 3 4 5 6 7 8 9 10

3. What you are concerned about?

   ☐ Missing tooth/teeth
   ☐ Cavities
   ☐ Gum disease
   ☐ Bad breath
   ☐ Straightness of teeth/bite
   ☐ Snoring
   ☐ Discoloration
   ☐ Appearance of your smile

4. Using a scale of 1 to 10, please rate your level of dental anxiety (10 being the highest level of fear/ anxiety).

   1 2 3 4 5 6 7 8 9 10

5. How would you like for us to review your treatment plan with you?

   _____ I am a big picture person, I prefer to review the plan looking at all the things that need to be done.

   _____ I am a detail oriented person, I prefer to approach each treatment step by step, along the way