Chart #: _____
FOR OFFICE USE ONLY

## Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

**Social Security #**: _____ **Birth Date**:_____
_____

Phone (Home): _____ (Work): _____ Ext:_____ Can We Call you at Work?_____

(**Cell**):_____**Email**_____

**Can we contact you by text Messaging? ____ Can we contact you by email? _____**

Address: _____
Street Apartment #

_____
City State Zip Code

Patient employed by:_____ Occupation:_____

Business address:_____
Street City State Zip

## Payment Responsibility Information
**(If you have insurance this needs to be filled out by the SUBSCRIBER of the insurance policy)**

Who is Responsible for Payment: ☐ Patient's Spouse ☐ Patient's Guardian/Parent ☐ Patient (if checked, do not complete the following)

Name: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other
_____

Social Security #: _____ Birth Date:_____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Do you have any Dental Insurance? ☐ YES ☐ NO
If yes, what is the name of your insurance company? _____

**Referral Information**

Whom may we thank for referring you to our practice? ☐ Another patient (friend or relative?) Name:_____

☐ Dental Office ☐ Yellow Pages ☐ Internet ☐ Work ☐ Sleep center/ Physician_____

# Health Information

Reason for today's visit: _____ Date of last dental visit::_____

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

- ☐ AIDS or HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Breast Implants
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Condition_____
- ☐ Hypertension
- ☐ Hepatitis A – B - C
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental/Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnant** Due Date**:**
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Stomach/Ulcer Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Irregular Heart Beat
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Latex Allergy
- ☐ Drug Allergy:

_____
_____
_____

OTHER:

- ☐ _____
- ☐ _____

**In case of an Emergency, who should we contact? Name_____ Phone #_____**

**Name of your Physician_____ Phone #_____**

**Please List any medications you are currently taking.**

_____
_____
_____
_____
_____
_____

Do you have a condition that requires you to be **Premedicated** with antibiotics? ☐ Yes ☐ No
If yes, please explain:
_____

Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain:_____

## Sleep Apnea Screening

Indicate if you have the following symptoms and how frequently they occur.
**Rarely or never** (1) **Some of the time** (2) **Frequently** (3) **Often or most of the time** (4)

__My snoring disturbs other people.
__I have been told that I snore loudly even when sleeping on my side.
__I have been told I snore only when sleeping on my back.
__I have been told that I stop "breathing" at night.
__I wake up "gasping for breath."
__I have been told that I grind or clench my teeth when sleeping.
__I wake in the morning with headaches.
__I feel excessively tired during the day.
__I fall asleep easily during the day.

Neck size_____
Height_____
Weight_____

## Financial Policy

Your payment is due at the time of service!

Patients who carry dental insurance understand that this office will file their insurance as a courtesy. And all **estimated** co-payments and deductibles are due at the time of service. **Our office only participates with Delta Dental** (Premier) and **Cigna DPPO**. We will file other insurances. *Also, the patient understands that he or she is personally responsible for payment for all dental services not covered by their insurance company.*

Patients who have an oral device made for a sleep disorder will pay in full at the time of service(s). Our office will file your medical insurance as a courtesy, except medicare and medicaid. **Our office is NOT a participating provider with any medical insurance.**

Patients who do not carry dental insurance understand that payment is due in full at the time of service.

A billing fee of $10 will be added to your account if two or more statements need to be sent. If there is a failure to pay your account it will be sent to a collection agency (plus our fee) and you will no longer be a part of this practice.

Allowable forms of payment are: Cash, Check, Money Order, Visa, Mastercard, Care Credit.

Patients will be charged **$40 for a cancellation same day as their appointment**. Patients will be charged **$50 for a broken appointment**. To guarantee no charge to your account our office needs to be notified 2 business days prior to the appointment. Our business days are Monday-Thursday.

You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any e-mail address you provide to use. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I have read this disclosure and agree that the Lender may contact me as described above.

If you have any questions, feel free to ask us. We will be glad to help.

I have read the above financial policy and I understand I am responsible for my account.

_____ Date: _____ Relationship to Patient:_____

Signature of patient, parent or guardian