

**We Welcome New Patients**

**ABOUT YOU**

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Age: \_\_\_\_\_ SS#: \_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_

Email: \_\_\_\_\_

Single  Married  Divorced  Widowed  Separated

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_

**Whom may we Thank for referring you?**

Other family members seen by us: \_\_\_\_\_

\_\_\_\_\_

**SPOUSE /PARENT INFORMATION**

Name: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Financial Responsibility for this account**

Name: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Relationship: \_\_\_\_\_ SS# \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Signature: \_\_\_\_\_

Signature must match name and ID on file

**DENTAL INSURANCE**

**Primary Dental Insurance**

Ins Co. Name: \_\_\_\_\_

Ins Co. Address: \_\_\_\_\_

Ins Co. Phone #: \_\_\_\_\_

**Group** (plan, local or policy) #: \_\_\_\_\_

**Member #:** \_\_\_\_\_

Insured Name: \_\_\_\_\_ Relation: \_\_\_\_\_

**Insured Birthdate:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Insured SS#** \_\_\_\_\_

Insured Employer: \_\_\_\_\_

**Secondary Dental Insurance**

Ins Co. Name: \_\_\_\_\_

Ins Co. Address: \_\_\_\_\_

Ins Co. Phone #: \_\_\_\_\_

Group(plan, local or Policy) #: \_\_\_\_\_

Member #: \_\_\_\_\_

Insured Name: \_\_\_\_\_ Relation: \_\_\_\_\_

**Insured Birthdate:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **SS#** \_\_\_\_\_

Insured Employer: \_\_\_\_\_

**MEDICAL & DENTAL HISTORY**

Do you have a personal physician? **Y N**

Physician's Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Last Visit Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of last physical exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Required: List Emergency Contact**

Their Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## MEDICAL HISTORY

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Have you ever had any of the following diseases or medical problems?**

Check Y column for Yes and N column for No.

<u>Y</u> <u>N</u>	<u>Y</u> <u>N</u>	<u>Y</u> <u>N</u>
<input type="checkbox"/> <input type="checkbox"/> Heart attack	<input type="checkbox"/> <input type="checkbox"/> Artificial Bones/Joints	<input type="checkbox"/> <input type="checkbox"/> Ulcers
<input type="checkbox"/> <input type="checkbox"/> Stroke	<input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/> <input type="checkbox"/> Hemophilia/Abnormal Bleeding
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> <input type="checkbox"/> Colitis
<input type="checkbox"/> <input type="checkbox"/> Chemotherapy	<input type="checkbox"/> <input type="checkbox"/> Sinus Problems	<input type="checkbox"/> <input type="checkbox"/> Congenital heart Defect
<input type="checkbox"/> <input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Anemia
<input type="checkbox"/> <input type="checkbox"/> Heart Murmur	<input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Arthritis
<input type="checkbox"/> <input type="checkbox"/> Heart Surgery	<input type="checkbox"/> <input type="checkbox"/> Do you snore	<input type="checkbox"/> <input type="checkbox"/> Asthma
<input type="checkbox"/> <input type="checkbox"/> Pacemaker	<input type="checkbox"/> <input type="checkbox"/> Depression/Mental Health	<input type="checkbox"/> <input type="checkbox"/> Emphysema
<input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> <input type="checkbox"/> Epilepsy/Seizures/Fainting	<input type="checkbox"/> <input type="checkbox"/> Hepatitis
<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/> Diabetes Last A1C ____	<input type="checkbox"/> <input type="checkbox"/> Blood Transfusion
<input type="checkbox"/> <input type="checkbox"/> HIV +/-AIDS	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis (TB)	<input type="checkbox"/> <input type="checkbox"/> Severe/Frequent Headaches
<input type="checkbox"/> <input type="checkbox"/> Shingles	<input type="checkbox"/> <input type="checkbox"/> Drug Abuse	<input type="checkbox"/> <input type="checkbox"/> Have you had a sleep study
<input type="checkbox"/> <input type="checkbox"/> Kidney Problems	<input type="checkbox"/> <input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> <input type="checkbox"/> Do you use a C Pap machine

**For Women:**

Y N

Birth Control?

Pregnant?

Nursing?

Planning Pregnancy?

**For Sedation purposes:**

**Approx Height:**

**Approx Weight:**

**Any medical conditions we should be aware of?**

<p><b>Are you allergic to the following drugs?</b></p> <table border="0" style="width: 100%;"> <thead> <tr> <th style="text-align: center;"><u>Y</u> <u>N</u></th> <th style="text-align: center;"><u>Y</u> <u>N</u></th> <th style="text-align: center;"><u>Y</u> <u>N</u></th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Penicillin</td> <td><input type="checkbox"/> <input type="checkbox"/> Tetracycline</td> <td><input type="checkbox"/> <input type="checkbox"/> Sulfa</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Aspirin</td> <td><input type="checkbox"/> <input type="checkbox"/> Dental Anesthetic</td> <td><input type="checkbox"/> <input type="checkbox"/> Latex</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Erythromycin</td> <td><input type="checkbox"/> <input type="checkbox"/> Codeine</td> <td><input type="checkbox"/> <input type="checkbox"/> Other</td> </tr> </tbody> </table>	<u>Y</u> <u>N</u>	<u>Y</u> <u>N</u>	<u>Y</u> <u>N</u>	<input type="checkbox"/> <input type="checkbox"/> Penicillin	<input type="checkbox"/> <input type="checkbox"/> Tetracycline	<input type="checkbox"/> <input type="checkbox"/> Sulfa	<input type="checkbox"/> <input type="checkbox"/> Aspirin	<input type="checkbox"/> <input type="checkbox"/> Dental Anesthetic	<input type="checkbox"/> <input type="checkbox"/> Latex	<input type="checkbox"/> <input type="checkbox"/> Erythromycin	<input type="checkbox"/> <input type="checkbox"/> Codeine	<input type="checkbox"/> <input type="checkbox"/> Other	<p><b>Please list any other drugs that you are allergic to:</b></p>
<u>Y</u> <u>N</u>	<u>Y</u> <u>N</u>	<u>Y</u> <u>N</u>											
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**Have you been hospitalized in the last 5 years? Why?**

Do you have artificial joint replacements? **Y N**    **If Yes, please explain:**

Do you need to take antibiotics prior to treatment? **Y N**

Are you currently under the care of a physician? **Y N**

**Have you traveled outside of the U.S. in the last 6 months? Y N**

**Do you smoke/vape or chew tobacco? Y N**

**MEDICATION LIST**

Patient Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Pharmacy Name/location: \_\_\_\_\_

Do you take any prescription or over-the-counter medications?  Yes  No

If yes, please list all medications below, including prescriptions, vitamins, supplements, and over-the-counter drugs

<b>Medication</b>	<b>Dosage</b> <i>mg,ml etc</i>	<b>Frequency</b> <i>1x day etc.</i>	<b>Reason</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any medication allergies?  Yes  No

<b>Allergic To</b> <i>medication name</i>	<b>Reaction</b> <i>rash, swelling, etc</i>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient or Guardian's Signature: \_\_\_\_\_ Date \_\_\_\_\_

## DENTAL HISTORY

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Your current Dental Health is:

Excellent       Good       Fair       Poor

How important is it that you retain your natural teeth?

Not important       Somewhat Important       Extremely Important

How important is dental treatment cost to you?

Not important       Somewhat Important       Extremely Important

Do you experience dental related anxiety?    **Y**    **N**

Do you or have you experienced pain/discomfort in your jaw joint (TMJ/TMD)?    **Y**    **N**

Do you like your smile?    **Y**    **N**

Do your gums ever bleed?    **Y**    **N**

How many times a week do you floss?

How many times a day do you brush?

Have you ever had serious or difficult problems associated with any previous dental work?

What concerns or goals would you like us to address at today's visit?

What influenced your decision to transition your care to our office?

**Payment for our services must be made in full at the time of scheduling your appointment, due to the nature of sedation, unless prior arrangements have been approved.**

Our office is dedicated to adhering to, and even surpassing, the infection control standards set forth by **OSHA**, the **CDC**, and the **ADA**.

**I understand** that the administration of local anesthetic may cause an unfavorable reaction or side effect, which may include, but are not limited to, bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely permanent numbness.

**I acknowledge** that the information I have provided today is accurate to the best of my knowledge. I also understand that this information will be treated with the utmost confidentiality, and it is my duty to notify this office of any changes regarding my medical condition. **I grant permission** for the dental staff to carry out any necessary dental services with my informed consent during the diagnosis and treatment process. Additionally, **I authorize** this office to arrange credit on my behalf if needed. Should my account go into delinquency, I will be responsible for all costs incurred during collection efforts, including attorney's fees, court costs, and a collection agency fee of 30%.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*by signing, you are agreeing you are the financial responsible party. Please ask the front desk for assistance.*



## MEDICAL INFORMATION RELEASE

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I, authorize Green Dental to disclose my medical and dental information to the following individuals: (we recommend spouse, anyone bringing you to a sedated appointment, anyone you would have call on your behalf)

Authorized Individuals:

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number \_\_\_\_\_
2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number \_\_\_\_\_
3. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number \_\_\_\_\_

I understand that these individuals may receive verbal, written, or electronic communication regarding my dental treatment, appointments, insurance, and billing inquiries.

**Authorized Methods of Contact** to myself as the patient: (Please check all that apply)

Home Phone  Cell Phone  Work Phone  Email  Text Message

**Messages:**

Leave a detailed message  Leave only a call-back number  Do not leave messages

I understand that this authorization will remain in effect unless I provide written notice to revoke or modify it. I also acknowledge that Green Dental cannot be held responsible for information released prior to the receipt of my written revocation.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## AUTHORIZATION FOR SUBMISSION OF CLAIMS AND ASSIGNMENT OF BENEFITS

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

### Authorization for Submission of Claims

I authorize Green Dental to submit insurance claims on my behalf and release necessary information, including dental history, diagnosis, and treatment, to process those claims.

I understand:

- A submitted claim does not guarantee payment.
- Any treatment plan is an estimate, not a guarantee of insurance coverage.
- I am responsible for understanding my insurance benefits.
- I am responsible for the full balance if insurance denies or delays payment.

### Assignment of Benefits

I assign all dental benefits to Green Dental and authorize direct payment from my insurance carrier.

I agree to:

- Forward any insurance payments sent directly to me within 30 days.
- Obtain referrals or pre-authorizations if required by my policy. I understand this is my responsibility, not the provider's.

### Financial Responsibility

I am responsible for any remaining balance after insurance processing. Payment is due at the time of service unless other arrangements have been made. Any balance must be paid within 30 days of insurance payment.

### Electronic Claims & Communication

I consent to the electronic submission of claims and communication between Green Dental and my insurance provider.

### Acknowledgment & Agreement

I have read, understand, and agree to the terms above. I accept financial responsibility for services provided and understand unpaid balances may incur additional fees or collection action.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## **CANCELLATION POLICY**

At Green Dental, we reserve dedicated time in our schedule for each patient to receive the highest level of care. When an appointment is missed or canceled without sufficient notice, it prevents other patients from receiving timely treatment.

### **Appointment Cancellations**

We kindly ask that all appointment cancellations or changes be made with at least 48 hours' notice. This allows us to offer that time to another patient in need.

### **No-Show Policy**

If a patient misses an appointment without notifying us, it will be considered a "no-show."

- After the first no-show, a friendly reminder of this policy will be shared.
- Any future missed appointments without 48-hour notice may result in a \$50 no-show fee added to the account.

### **Running Late?**

We understand that life happens. If you're running behind, please call us as soon as possible. We'll do our best to accommodate you or find an alternative time.

We value your time, and we hope to offer that same courtesy to every patient. These guidelines help us:

- Minimize wait times
- Ensure efficient scheduling
- Keep treatment plans on track for all patients

### **Acknowledgment**

As a patient of Green Dental, I have read, understand, and acknowledge this cancellation and no-show policy.

Name: \_\_\_\_\_ Date: \_\_\_\_\_