PATIENT INFORMATION

Patient First Name ___________________________________ Last Name ___________________________________ MI _____

Preferred Name ________________________ Date of Birth ________________ Social Sec Number ______________________

Address ____ City _______________________ State _____ Zip ________

Home Phone _______________________________________ Work Phone ___________________________________ ext ______

Cell Phone ____ E-mail Address ____

I would like to receive electronic communication regarding appointments (circle) **TEXT** **E-MAIL** **NOT AT THIS TIME**

Whom may we thank for referring you? ____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

Subscriber Name ______________________________________

Subscriber Date of Birth _________________________________

Relationship to Patient __________________________________

Employer Name ____

Insurance Company _____________________________________

Insurance Phone _______________________________________

Subscriber ID ____

Insurance Group ____

SECONDARY INSURANCE

Subscriber Name ______________________________________

Subscriber Date of Birth _________________________________

Relationship to Patient __________________________________

Employer Name ____

Insurance Company _____________________________________

Insurance Phone _______________________________________

Subscriber ID ____

Insurance Group ____

RESPONSIBLE PARTY *(if minor)*

First Name ____ Last Name ___________________________________ MI _____

Relationship to Patient______________________ Date of Birth ________________ Social Sec Number ____________________

Address ____ City _______________________ State _____ Zip _________

Home Phone _______________________________________ Work Phone ___________________________________ ext ______

Cell Phone ____ E-mail Address ____

EMERGENCY CONTACT

Name: ____

Phone Number: _______________________________________

Relationship to Patient: ______________________________

Phone Number: ____

DENTAL HISTORY *(new patients only)*

Reason for today's visit _________________

____

Former Dentist _________________________

City/State ____________________________

Date of last dental visit _________________

Date of last dental x-rays ________________

How often do you floss? _________________

How often do you brush? ________________

Please answer **YES** or **NO** to indicate if you have had any of the following:

Condition		
Bad Breath	Yes	No
Bleeding gums	Yes	No
Blisters on lips or mouth	Yes	No
Burning sensation on tongue	Yes	No
Chew on one side of mouth	Yes	No
Cigarette, pipe or cigar smoking	Yes	No
Clicking or popping jaw	Yes	No
Dry mouth	Yes	No
Fingernail biting	Yes	No
Food collecting between teeth	Yes	No
Foreign objects	Yes	No
Grinding teeth	Yes	No
Gums swollen or tender	Yes	No
Jaw pain or tiredness	Yes	No
Lip or cheek biting	Yes	No
Burning sensation on tongue	Yes	No
Mouth breathing	Yes	No
Mouth pain, brushing	Yes	No
Orthodontic treatment	Yes	No
Pain around ear	Yes	No
Periodontal treatment	Yes	No
Sensitivity to cold	Yes	No
Sensitivity to heat	Yes	No
Sensitivity to sweets	Yes	No
Sensitivity when biting	Yes	No
Sores or growths in mouth	Yes	No

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have dental insurance coverage with ________________________ and assign directly to **Bolt Family Dental** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

I authorize that **Bolt Family Dental** may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

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Please Print Name

____ ____________________

Signature Date

Medical History

Patient Name ____ Date of Birth _______________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you currently under a physician's care? Yes No If yes, please explain ____

Are you currently taking any medications? Yes No If yes, please list ____

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Are you allergic to any of the following? (circle) Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa

Other allergies ____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain ______________________________

Have you ever had a serious head or neck injury? Yes No If yes, please explain ______________________________

Do you need to pre-medicate prior to dental procedures? Yes No If yes, please explain ______________________________

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Do you take, or have you ever taken, Phen-Fen or Redux? Yes No

Women: Are you currently pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Glaucoma	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Genital Herpes	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain ______________________________

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Comments ____

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or my dependents) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN ______________________________ DATE ____________________

FINANCIAL POLICY

Dear Patient, Parent or Guardian,

Bolt Family Dental is more than happy to cooperate with individuals who are covered with dental insurance and as a courtesy to you, we will file your dental insurance claim on your behalf. We ask that you carefully read your dental policy to be sure you are fully aware of any restrictions that may apply to the benefits provided. Please note, dental insurance is a contract between the insured and the insurance company, **IT IS NOT A CONTRACT BETWEEN THE DENTIST AND THE INSURANCE COMPANY.**

If a quote is given to you at any time, this is an ***ESTIMATE ONLY.*** If your insurance does not pay what is quoted to you, you are responsible for the balance. We are always willing to send in a pre-treatment estimate prior to any dental treatment. **PLEASE REMEMBER THAT YOU ARE RESPONSIBLE FOR YOUR CO-PAYMENT AND ALL DEDUCTIBLES AT THE TIME SERVICE IS RENDERED.** Please let us know if we can answer any further questions concerning your dental benefits.

Lastly, by signing below you agree to be responsible for the payment of all services rendered on your behalf or on behalf of your dependents. You, (patient, parent or guardian) understand that payment is due at the time services are rendered unless other arrangements have been made prior to any dental treatment. In the event payments are not received by agreed upon dates, you understand that a 1.5% finance charge (18% APR) may be added to your account. You shall also be responsible for any and all costs incurred from collecting the account should the account become delinquent.

Thank you,

Bolt Family Dental

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Please Print Name

____ ____________________

Signature *Date*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, ___________________________, acknowledge that I have received a copy of this offices Notice of Privacy Practices.

____

Please Print Name

____ _____________________

Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ Individual refused to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (Please Specify) ____