PATIENT INFORMATION
(Please print)

_____

First **Middle** **Last** **Jr/Sr**

_____

Street **City** **State Zip**

( ) **( )**

_____

Home Phone **Cell Phone**

_____**M or F**

Patient Social Security Number **Patient Date of Birth** **Sex**

( )

_____

Emergency Contact **Phone Number**

How did you hear about us?_____
(Please be as specific as possible)

INSURANCE INFORMATION

Do you have dental insurance? ( ) Yes ( ) No
Do you have secondary dental insurance? ( ) Yes ( ) No

PRIMARY INSURANCE
Subscriber Name:_____
Subscriber SSN:_____
Date of Birth:_____
Relationship to subscriber
( )Self ( )Spouse ( )Child ( )Other
Employer Name:_____
Employer phone #:_____
Insurance Company:_____
Insurance Group #:_____

SECONDARY INSURANCE
Subscriber Name:_____
Subscriber SSN:_____
Date of Birth:_____
Relationship to subscriber
( )Self ( )Spouse ( )Child ( )Other
Employer Name:_____
Employer phone #:_____
Insurance Company:_____
Insurance Group #:_____

***Please present insurance card to receptionist to be photocopied**

PATIENT MEDICAL HISTORY

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. It is the patient's responsibility to keep us up to date on any changes in medical history.

General Health: Good [ ] Fair [ ] Poor [ ]

Physician's Name _____ Last complete physical _____
Ph# ( ) _____

Are you currently on any medications? Yes [ ] No [ ]
If "Yes, please list medications and purpose:

_____ _____

_____ _____

_____ _____

Please check 'Yes' or 'No' boxes which apply to you and your medical history:

Y	N	Medical History	Y	N	Medical History
		Need antibiotic coverage prior to dental work			(women) Currently pregnant? #weeks?
		Artificial joint replacement			(women) Currently nursing?
		Undergone radiation or IV chemotherapy			(women) Taking birth control pills?
		Use or have used tobacco products			Ever taken Phen-Fen (Redux or Podimin)?
		Subject to prolonged bleeding			Have metal rods, pins or implants
		Subject to fainting			Recently hospitalized for a major surgery

Please check 'Yes' or 'No' boxes if you are currently, or have ever been diagnosed or treated for:

Y	N	Medical Conditions	Y	N	Medical Conditions	Y	N	Medical Conditions
		Abnormal bleeding/hemophilia			Emphysema			Mitral valve prolapse
		AIDS/HIV			Epilepsy			Pacemaker
		Alcohol/Drug Abuse			Frequent headaches			Psychiatric Problems
		Anemia			Glaucoma			Radiation Treatment
		Arthritis			Hay Fever			Rheumatic/Scarlet Fever
		Artificial joints/bones/valves			Heart Attack			Seizure
		Asthma			Hepatitis			Shingles
		Blood transfusion			Herpes			Sinus problems
		Cancer			HIV			Stroke
		Congenital heart defect			Kidney Disease			Thyroid problems
		Diabetes			Liver Disease			Tuberculosis (TB)
		Difficulty breathing			Abnormal Blood Pressure			Ulcers/colitis
		Eating Disorder			Lupus			Venereal Disease

Please list any other medical condition which is not listed: _____

Do you have any allergies? Yes [ ] No [ ]

If 'yes', please circle or list:

Aspirin Codeine Dental Anesthetics Erythromycin Jewelry/Metals Latex Penicillin Tetracycline Other

PATIENT DENTAL HISTORY

What is the reason for today's visit? _____
Last dental visit _____ Date of last dental x-rays _____
Have you ever had a serious problem associated with a previous dental treatment? Yes [ ] No [ ]
If 'yes', please explain: _____

What dental aids do you use regularly? [ ] Floss [ ] Water pick [ ] Electric/sonicare Toothbrush Perio Aid [ ]

Please check any of the following which apply to you:

[ ] Gums bleed during brushing or flossing
[ ] Gums feel tender or swollen
[ ] Frequent sensitivity to hot, cold, sweets
[ ] Usually break fillings or teeth
[ ] Pain with biting or chewing
[ ] Breath through your mouth
[ ] Regularly clench or grind teeth
[ ] Bad odors or tastes in mouth
[ ] Experience jaw discomfort (TMJ/TMD)
[ ] Currently (or previously) use a mouth guard or splint
[ ] Frequent cold sores, blisters or other oral/lip lesions
[ ] Food frequently gets caught between your teeth
[ ] Previous (or current) Periodontal (gum) surgery
[ ] Previous (or current) Orthodontic treatment
[ ] Previous (or current) speech problem
[ ] Previous (or current) trauma to the mouth, face or teeth
[ ] Previous (or current) biopsy of the mouth, lips or face
[ ] Still have wisdom teeth

Do you like your smile? Yes [ ] No [ ]
If not, what would you like to change? _____

CONSENT FOR TREATMENT

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in medical status. I hereby authorize the dental staff to perform any necessary dental services required during diagnosis and treatment, with my informed consent. I understand that there are certain risks inherent in dental treatment; such as but not limited to: pulpal sensitivity or damage, tissue swelling or damage, soreness of jaw, paresthesia and other procedure specific risks.

Insurance Release and Responsibility for Payment: I authorize release of information regarding my dental treatment to my insurance carrier. I agree to be responsible for payment on services rendered during any ineligible insurance period and any balance not covered by the insurance carrier. I understand that insurances are billed as a courtesy and that I am ultimately responsible for all costs of treatment.

I have read and agree to comply with the office policies and Privacy Policies (HIPPA) described on the next page.

Signature _____ Date _____
(If patient is a minor, Parent or Guardian must complete the section below and sign here)

RESPONSIBLE PARTY (please print)

_____
First Middle Last Jr/Sr

_____
Street City State Zip

( ) ( )
_____
Home Phone Cell Phone

_____M or F
Social Security Number Date of Birth Sex

OFFICE POLICIES

Please review and keep this copy of our office policies for your personal records.

Financial Policies

In the interest of good dental practice, it is desirable to establish a credit policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good dental health and we wish to spend our time and energy on that end.

To assist our patients, we offer the following methods for taking care of their account at our office:

- We accept credit cards (Visa, MasterCard & Discover)
- As a courtesy, we will gladly bill your insurance when you provide us with the most current information. Often times we are able to contact your insurance provider prior to your appointment, and estimate your portion of the bill. We ask that you pay your portion of the bill at time of service, or that a suitable financial agreement be reached at time of service. Insurance policies are a contract between you, your employer and your insurance carrier. Therefore, you are ultimately responsible for the payment of your account.
- For patients who qualify, we offer payment plans through a third party Financing Company. There are numerous payment options that will fit comfortably in almost any monthly budget.
- We offer a discount to patients who pay by cash on the day of service.

Missed or Cancelled Appointments

We kindly ask that patients give us a minimum of 24- hour notice if unable to keep an appointment. There will be a minimum deposit of $25 required before we will make you another appointment. Our patient's time is very valuable to us. When you make an appointment, we have reserved a time slot and a room for you. If you fail to keep an appointment that time slot could have been given to another patient who is in need of care. We will not offer appointments to patients who fail to keep multiple appointments without giving proper notice. You may leave a message on our after-hours answering machine if you find you are unable to honor an appointment and our office has closed for the day. If you are 15 minutes or later for an appointment we will kindly ask that you reschedule your appointment and you may not be seen that day.

Estimates and Fees

After x-rays and examination, you are entitled to and should ask for an estimate of fees to cover your treatment. All estimates are based upon conditions viewed at the time of diagnosis. Unforeseen circumstances such as pulpal therapy or cracked teeth could alter an estimated fee. It is customary to pay for dental services when they are rendered. Except in extreme emergencies, financial arrangements are made before your treatment is rendered. A refundable deposit may be required to make appointments longer than 45 minutes to hold the appointment slot. Upon arrival to that appointment the deposit can be added to your account or refunded.

Dental Specialties

Nova Dental LLC offers a full range of dental professionals and services under one roof. Services include orthodontics, oral surgery, and pediatric dentistry. Endodontic, general dentistry, prosthetic, dentures, cosmetic, preventative, restorative, and TMJ services are also available.

Notice of Privacy Practices (HIPPA)

A laminated copy of our office Notice of Privacy Practices (HIPPA) is available in our office and is attached to your clipboard for your review. We ask that you review the policies before signing the previous page. Upon your request, we will be happy to provide you with your own personal copy of our Privacy Practices.

Welcome to our office and we hope that your time here is enjoyable, informative and helpful. Please let us know if you have any questions, comments or concerns.