Patient Name _____ Date of birth _____

Primary reason for this dental appointment □ Examination □ Emergency □ Consultation

Dental History

Please circle

Do you have a specific dental problem? Describe _____ Yes No

Do you have dental examinations on a routine basis? Last visit? _____ Yes No

Name of previous dentist? _____ Xrays taken? _____ Yes No

Do you think you have active decay or gum disease? Do your gums bleed? _____ Yes No

Do you brush and floss on a routine basis? _____ Yes No

Do you clench or grind your teeth? Do your gums bleed? _____ Yes No

Do you like your smile? If no, what would you like to change? _____ Yes No

Does food catch between your teeth? Do you have any loose teeth? _____ Yes No

Do you want to keep your remaining teeth? _____ Yes No

Do you ever have popping, clicking or discomfort in your jaw? _____ Yes No

Do you smoke or chew? How often/much? _____ Yes No

Have your experiences in a dental office always been positive? _____ Yes No

Medical History

Are you under a physicians care now? _____ Yes No

Who? _____ Why? _____ Phone Number? _____

Have you been hospitalized or had a major operation? _____ Yes No

Have you had a serious injury to your head or neck? Discuss _____ Yes No

Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What? _____ Yes No

_____

Are you on a special diet? Discuss _____ Yes No

Are you allergic to any medications or substances? Please check box below _____ Yes No

□Aspirin □Penicillin □Codeine □Acrylic □Metal □Latex Rubber □Milk □Other _____

Women, are you (please check) □Pregnant/Trying to get pregnant □Nursing □Taking oral contraceptives □None of the above

Do you have or have you had any of the following? Please check appropriate boxes

□ Heart Attack/Failure	□ Bisphosphonate Meds	□ Excessive Thirst	□ Lung Disease	□ Thyroid Disease
□ Heart Pace Maker	□ Blood Transfusion	□ Fainting/Dizziness	□ Night sweats	□ Tuberculosis
□ Artificial Heart Valve	□ Blood Disease	□ Frequent Cough	□ Osteonecrosis of jaw	□ Ulcers
□ A-Fib	□ HIV/AIDS	□ Frequent Diarrhea	□ Osteoporosis	□ Unexplained Fever
□ Pulmonary Shunt	□ Cancer	□ Genital Herpes	□ Psychiatric Care	□ Yellow Jaundice
□ Congenital Heart Disorder	□ Leukemia	□ Glaucoma	□ Recent Weight Loss	□ ADD/ADHD
□ Heart murmur/defect	□ Chemotherapy	□ Heart Disease	□ Parkinson's Disease	□ Lupus
□ Mitral Valve Prolapse	□ Radiation Treatment	□ Hemophilia	□ Rheumatic Fever	□ Mental Disorder
□ Angina/Chest pain	□ Tumors/Growths	□ Hepatitis A	□ Rheumatism	□ Nervous Disorder
□ Artificial joint(s)	□ Cochlear Implants	□ Hepatitis B or C	□ Scarlett Fever	□ Fibromyalgia
□ Alzheimer's Disease	□ Cold Sores	□ High Blood Pressure	□ Shortness of Breath	□ Crohn's Disease
□ Anemia	□ Cortisone Medications	□ Low Blood pressure	□ Sinus Trouble	□ Drymouth
□ Liver Disease	□ Diabetes A1C? _____	□ Hives	□ Sleep apnea	□ Hormone Treatment
□ Bruise Easily	□ Drug/Alcohol Addiction	□ Hypoglycemia	□ Stomach/Intestinal Disease	□ Auto Immune Disorder
□ Arthritis/Gout	□ COPD	□ Irregular heart beat	□ Stroke	□ High/Low Cholesterol
□ Asthma	□ Emphysema	□ Kidney Problems	□ Swelling of limbs	□ GERD/Acid Reflux
□ Bacterial Endocarditis	□ Epilepsy/Seizures	□ Renal Dialysis	□ Tattoos/Body Piercing	□ Traumatic Brain Injury

Have you had any other serious illness not mentioned above? Discuss _____ Yes No

Do you wish to talk to the dentist privately about any problem? _____ Yes No

*To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at the next appointment without fail.

_____

Patient or Parent Signature Date

_____

Reviewed by Doctor Date

PATIENT INFORMATION

DATE: _____

Name: _____

SSN: _____ Married_____ Single_____ Minor_____ Male_____ Female_____

ADDRESS: _____ _____
Street Apt#

_____
City State Zip Code

BIRTHDATE: _____ TELEPHONE: _____ _____
*May we text this number re: appointments? YES _____ NO _____

E-MAIL ADDRESS: _____ _____

NAME OF EMPLOYER: _____ _____Phone: _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: Patient____ Guardian____ Spouse____ Father____ Mother____

PRIMARY INSURANCE INFORMATION			SECONDARY INSURANCE INFORMATION		
Last	First	MI	Last	First	MI
Birthdate	SSN:		Birthdate	SSN:	
Employer			Employer		
Dental Insurance Company			Dental Insurance Company		
Subscriber #		Group #	Subscriber #		Group #

Who may we thank for referring you to our office? _____

Person to Contact in Case of an Emergency: _____
Name Phone Relationship

Authorization

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

_____
Patient Signature Date

_____
Guardian Signature Date

Welcome to Generations Dental!

We are glad you have chosen us to take care of your oral health. We are excited to have you be a part of our practice. We look forward to helping you achieve and maintain a beautiful, healthy smile.

Your First Visit

Our goal for your first visit is to perform a comprehensive exam to evaluate your overall dental health. This will likely involve x-rays to check for cavities and an examination of your gums to determine what type of cleaning you should have. We will also need to review your medical history, including any medications you take and any past illnesses or surgeries. There is space provided to list additional medical conditions that may not be included in our form's checklist. This is to help ensure we are able to recommend the best possible care for you. If you have X-rays taken at another office within the last year, please let us know, as we can probably acquire them.

Appointments

To ensure we are able to see all our patients in a timely fashion we ask that you please provide notice of cancellation 24 hours prior to your appointment. We understand that emergencies do arise and those will be taken into consideration. However, we do reserve the right to assess a $30.00 cancellation fee if you fail to keep appointments without proper notice.

Office Hours:

Monday: 9:00am-5:00pm, Tuesday-Thursday: 7:00am – 3:00pm. Friday: By appointment

Acknowledgement of Privacy Practices

Your signature below confirms that you have been informed of your rights to privacy regarding protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

A copy of our privacy practices can be made available for you at your request. Please ask the front desk if you would like to retain a copy.

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Additionally, I give consent for Dr. Rader and/or his representatives to discuss my health with the following:

_____

Dental Insurance

Our office is committed to providing the best treatment possible for our patients. Our fees reflect usual and customary rates for our area. The rates paid by your dental benefit carrier are set by the carrier in consultation with your employer. For some procedures, their reimbursement rate has no bearing on the real usual and customary rates for our local area. In addition, their refusal to cover a particular procedure has no reflection on the necessity of the procedure or of the resulting value of procedure to your oral health.
If you have dental insurance, we will gladly file your claim for you. We will also try to estimate what portion of your fees will be covered by your insurance. However, we cannot guarantee these estimates and the ultimate decision is made by your insurance. To eliminate any confusion about insurance coverage, we may have the insurance provide us with a predetermination of your benefits prior to starting major treatment. We work hard to get your insurance to help cover the cost of your treatment, but sometimes insurance simply will not cover everything that is needed for optimal care.

If you do not have dental insurance please inquire with our staff for more information on our in-office dental program.

Financial Arrangements
We are committed to making sure you are able to receive the treatment we recommend. Understanding that each of us has unique financial needs we are happy to offer payment options to fit into your budget. We offer a 5% cash/check discount for patients that do not have insurance on services that are paid in full the day of service or earlier and a 12% discount to any US Military veteran receiving services in our office.
A finance charge of 1% will be imposed monthly on those charges not paid in full within 90days of service. Any unpaid balance remaining after reasonable attempts to collect by our office will be transferred to a collection agency. Upon transfer a $200 or 30% (whichever is greater) collection fee will be added to your balance.
For any patient needing to make payments on proposed treatment plans, we are partners with CareCredit, a company that can finance your treatment for you and offer interest free payments for several months. If you are interested in CareCredit please ask for a pamphlet detailing their payment plans.

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Media Release (Optional)
Generations Dental has my permission to use any images taken for use on social media, including but not limited to promotional video, web pages, Youtube, Twitter and/or Facebook for informational purposes, promotions and marketing.

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____