

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to complete this form.

Patient Information

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Phone home _____ Office _____ Cell _____

Male ___ Female ___ Birth date _____ Social Security Number _____

Single ___ Married ___ Widowed ___ Divorced ___

Can we leave a detailed message at your home or cell? Yes No

Is it okay that we text you a message? Yes No Email? Yes No

Email Address _____

Patient employed by _____ Occupation _____

Whom may we thank for referring you? _____

In case of emergency please contact _____

Phone _____ Relationship _____

Insurance Information

Person responsible for account _____

Relationship to the patient _____ Birth date _____ Social Security # _____

Address (if different from patient) _____

City _____ State _____ Zip _____

Business Name/Phone _____

Insurance Company Name/Phone _____

MEDICAL HEALTH HISTORY

PATIENT NAME: _____ **Date:** _____

A. CIRCLE YOUR ANSWERS (leave BLANK if you do not understand the question):

- 1. Yes No Are you in good health?
- 2. Yes No Has there been a change in your health within the last year? Explain: _____
- 3. Yes No Have you been hospitalized or had a serious illness in the last 5 years? Explain: _____

4. Yes No Are you being treated by a physician now? For what? _____

Name of your physician: _____ Date of last Medical Exam: _____

B. HAVE YOU EVER EXPERIENCED?

- | | |
|---|---|
| 5. Yes No Chest Pains | 15. Yes No Dizziness |
| 6. Yes No Swollen Ankles | 16. Yes No Ringing in ears |
| 7. Yes No Shortness of breath | 17. Yes No Frequent Headaches |
| 8. Yes No Recent weight loss, fever, night sweats | 18. Yes No Fainting spells |
| 9. Yes No Persistent cough, coughing up blood | 19. Yes No Blurred Vision |
| 10. Yes No Bleeding problems, bruising easily | 20. Yes No Seizures |
| 11. Yes No Sinus Problems | 21. Yes No Excessive thirst |
| 12. Yes No Difficulty swallowing | 22. Yes No Frequent urination |
| 13. Yes No Joint pain, stiffness | 23. Yes No Dry Mouth |
| 14. Yes No Jaundice | 24. Yes No Sleep apnea or chronic snoring |

C. DO YOU HAVE OR HAVE YOU HAD:

- | | |
|---|--|
| 25. Yes No Heart disease | 36. Yes No HIV positive or AIDS-ARC |
| 26. Yes No Heart attack, heart defects, | 37. Yes No Tumors, Cancer |
| 27. Yes No Heart murmur | 38. Yes No Arthritis, rheumatism |
| 28. Yes No Rheumatic fever | 39. Yes No Eye disease |
| 29. Yes No Stroke, hardening of arteries | 40. Yes No Skin disease |
| 30. Yes No High Blood Pressure | 41. Yes No Anemia |
| 31. Yes No TB, emphysema or other lung diseases | 42. Yes No VD (syphilis or gonorrhea) |
| 32. Yes No Hepatitis, A B C | 43. Yes No Herpes |
| 33. Yes No Stomach problems, ulcers | 44. Yes No Kidney, bladder diseases |
| 34. Yes No Diabetes | 45. Yes No Thyroid, adrenal diseases |
| 35. Yes No Mitral Valve Prolapse | 46. Yes No History of diabetes, heart problems, cancer |

D. DO YOU HAVE OR HAVE YOU HAD:

- | | |
|-------------------------------------|--|
| 47. Yes No Surgeries _____ | 52. Yes No Radiation Treatments |
| 48. Yes No Blood Transfusions _____ | 53. Yes No Chemotherapy |
| 49. Yes No Artificial Joint _____ | 54. Yes No Prosthetic heart valve |
| 50. Yes No Contact Lenses _____ | 55. Yes No Pacemaker |
| 51. Yes No Psychiatric Care _____ | 56. Yes No Birth Control Pills (Women only) |
| | 57. Yes No Pregnant or nursing (Women only) |

E. DO YOU TAKE OR HAVE TAKEN:

- 58. Yes No Recreational drugs
- 59. Yes No Alcohol
- 60. Yes No Tobacco in any forms
- 61. Yes No Phen Phen diet Pills or any other diet pills
- 62. Yes No Fosamax

F. VITAMINS & MEDICATIONS: _____

ALLERGIES: LATEX, ANY DRUGS, FOODS, MEDICATIONS, METALS, JEWELRY, ACRYLICS, ETC, please list allergies:

G. ALL PATIENTS:

63. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain:

64. Yes No Have you ever been told by a physician or dentist that you need to pre-medicated prior to any dental treatment?

DENTAL HEALTH HISTORY

H. Name of your Former Dentist: _____ How long since you were last seen? _____

65. Is keeping your teeth important to you? [Y] [N] If yes, why? _____

66. On a scale of 1-10, 10 being the best, where would you rate your smile?

67. On a scale of 1-10, 10 being the best, where you rate your oral health?

68. Have you experienced any of the following problems:

Bleeding gums [Y] [N],

Bad Breath or sour taste in mouth [Y] [N]

Burning sensations in mouth [Y] [N]

Soreness in jaw [Y] [N],

Is it hard for you to open wide? [Y] [N]

Clicking or popping in jaw [Y] [N]

Have you or your parents suffer(ed) from Gum Disease? [Y] [N]

Did you ever wear braces? [Y] [N]

Oral Surgery of any kind? [Y] [N]

Sensitivity to Hot & Cold [Y] [N]

Snoring [Y] [N]

Food catching between teeth [Y] [N]

Clenching or Grinding of Teeth [Y] [N]

Pain/soreness around ears, eyes, face [Y] [N]

Stiff neck muscles [Y] [N]

Do you or your parents wear dentures/partials? [Y] [N]

Ever been injured in your mouth or head? [Y] [N]

Do you smoke or chew tobacco? [Y] [N]

70. Does having dental treatment make you afraid or nervous? [Y] [N] If yes, what specific things bother you? _____

71. Is the brightness of your teeth important to you? [Y] [N]

72. If you could change anything about your smile which of the following would you want?

Whiter [Y] [N]

Close space or spaces [Y] [N]

Replace chipped teeth [Y] [N]

Replace missing teeth [Y] [N]

Replace old crowns [Y] [N]

Remove silver fillings [Y] [N]

Remove Stains/Spots on teeth [Y] [N]

Excess showing of Teeth [Y] [N]

Replace old plastic filling(s) [Y] [N]

Straighter [Y] [N]

Less Gum showing [Y] [N]

Reshape/resize my teeth [Y] [N]

73. Fill in this question for us please: Where do you see your overall oral health and/or your smile in the next 5 to 10 years?

74. Please circle the following which are important to you when making your dental health decision.

Convenience

Appearance

Relationship with Dental Team

Finances

Time

Quality of care

What insurance covers

Health

Detailed treatment explanations

Fear or Anxiety

Comfort

Technology

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

Photographic Release

In our office we like to photograph our patients to aid Dr. Titensor in determining dental problems and the solutions/treatment options for them. Dr. Titensor sometimes uses the photographs, with the patients permission, to teach dentists all over the world how we create beautiful smiles for our patients.

We are very proud of the work we have done and use only our own patient's photographs in our marketing and advertising. All of the portraits in our office and on the website (www.smilesbysteve.com) and in our ads are our own patients.

Authorization and release:

I hereby authorize Dr. Titensor to use photos of my face, jaws, and teeth. I understand that the photos may be used as a record of my care and may be used for educational purposes in lectures, demonstrations, and advertising. (Including website, magazines, phonebooks, television) and professional publications. I further understand that if my photos are used in any way described above that my name and identifying information will be confidential. I do not expect compensation, financial or otherwise for use of these photos.

X-ray Information

X-rays provide invaluable information to Dr. Titensor for diagnosing and treatment planning. To provide a comprehensive examination, x-rays are required. There are a variety of x-rays; each provides a variety of information. Dr. Titensor will recommend x-rays based on your individual needs.

Our x-ray system is digital which results in the lowest possible exposure to radiation. We are able to view the films immediately.

Insurance companies limit the types and the frequency that some x-rays are taken. It is our responsibility to provide a comprehensive evaluation to you. By limiting the allowance of x-rays Dr. Titensor cannot present a complete evaluation to you. If there are x-rays recommended to you that are declined, we will require a signed release of liability from you stating that you fully understand that there are conditions that cannot be diagnosed without them.

I have read the information regarding x-rays and fully understand Dr. Titensor's philosophy. I understand that my insurance company limits frequency of some types of x-rays and if I am in a situation that requires services not covered, I will be responsible for the fees associated with the service.

Patient signature: _____

Date: _____

Our Financial Philosophy

Thank you for selecting our office for your dental care. It is important to us that the quality of our business services match the quality of your dentistry. We want the handling of your account, from the start through final payments to be perceived as an extension of the dental care we provide you and your family.

Patients Role

As with any partnership, both parties have a role to play. Our role is to provide you with quality service and are committed to the success of your treatment. In turn, your role is to pay for your treatment in a timely manner. Our team will work with you to determine financial arrangements that make sense for both of us. With an agreement made, our joint follow-through will result in a win for everyone.

In developing a financial arrangement it is important to remember your dental future. Our experience has shown that when an account lingers patients are likely to defer their appointments. It is discouraging to add new charges to an account when trying to pay off old charges. With this in mind, we will concentrate our efforts on clearing your account in as short amount of time as is comfortable for both of us.

Regarding Insurance

We will gladly file dental claims for your treatment once your coverage and benefits have been verified. We ask all patients to complete our Patient Information Packet before seeing the doctor as that insures our office of obtaining the correct information to better serve you in regards to your benefits. Your *estimated* co-pay and deductibles will be collected as treatment progresses. These numbers are only *estimates* as your insurance company is unable to provide exact information to us because your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Also for this reason, if your policy is based off of a fee schedule you will need to provide our office with a copy of the schedule.

We may accept assignment of insurance benefit's, however the balance is your financial responsibility regardless of what insurance doesn't cover. We ask that you provide us with complete and accurate insurance information so we may file to your insurance company. If your insurance company has not paid on your claim within 45 days, the full balance will automatically be transferred to you and will be due upon billing.

- Yes, Please file a claim to my insurance provider on my behalf.**
- No, I DO NOT want you to file a claim. I will pay in full and file my own claim.**
- What is your preferred method of payment? _____**

WE ACCEPT CASH, CHECK, VISA, MASTER CARD, DISCOVER AND AMERICAN EXPRESS

WE OFFER ACCESS TO EXTENDED PAYMENT PLANS WITH CREDIT APPROVAL

