



ACE FAMILY DENTAL CARE NEW PATIENT FORM

PATIENT DETAILS

Name : _____
 Last Name First Name Middle Name Title

Preferred Name : _____ Male Female

Address : _____ City : _____ State : _____ Zip : _____

SSN : _____ Date of Birth : _____

Home Phone : _____ Work Phone : _____

Cell Phone : _____ Email Address : _____

Employer : _____ Occupation : _____

Marital Status : Domestic Partner Single Married Divorced Widowed Separated

How did you hear about our office? _____

NOTE: We will contact you by Email and/or by Phone for appointment confirmation.

INSURANCE - Primary

Subscriber Name : _____ Relationship to Patient : _____ Subscriber DOB: _____

Subscriber SSN / ID : _____ Subscriber Employer : _____

Insurance Co. Name : _____

Insurance Co. Address : _____

Insurance Co. Phone : _____ Group Number : _____

INSURANCE - Secondary

Subscriber Name : _____ Relationship to Patient : _____ Subscriber DOB: _____

Subscriber SSN / ID : _____ Subscriber Employer : _____

Insurance Co. Name : _____

Insurance Co. Address : _____

Insurance Co. Phone : _____ Group Number : _____

ASSIGNMENT & RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to **Ace Family Dental Care** 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 hereby authorize the Dentist to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature : _____

Relationship : _____ Date : _____

CONSENT

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient / Guardian Signature : _____



Patient Name : _____ Date of Birth : _____

MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____ Physician's Phone: _____ Date of Last Visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please Explain _____

Do you use tobacco in any form? Yes No

Have you had any metal rods, pins or implants placed? Yes No

Are you taking any medications? Yes No

Please list each one _____

Have you ever had any surgical procedures? Yes No

Please list each one _____

| | | | |
|---------------|--|---|--|
| Women: | Are you taking Birth Control Pills? | Are you pregnant? | Are you are Nursing? |
| | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No If so, # of Weeks _____ | <input type="radio"/> Yes <input type="radio"/> No |

Are you allergic to any of the following? Aspirin Penicillin Codeine Dental Anesthetics
 Erythromycin Jewelry Latex Metals Tetracycline

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

- | | | |
|---|---|--|
| <input type="radio"/> Abnormal Bleeding | <input type="radio"/> Fainting Spells | <input type="radio"/> Psychiatric Problems |
| <input type="radio"/> Alcohol Abuse | <input type="radio"/> Fever Blisters | <input type="radio"/> Radiation Therapy |
| <input type="radio"/> Allergies | <input type="radio"/> Frequent Headaches | <input type="radio"/> Rheumatic Fever |
| <input type="radio"/> Anemia | <input type="radio"/> Glaucoma | <input type="radio"/> Seizures |
| <input type="radio"/> Angina Pectoris | <input type="radio"/> HIV + AIDS | <input type="radio"/> Sexually Transmitted |
| <input type="radio"/> Arthritis | <input type="radio"/> Heart Attack | <input type="radio"/> Shingles |
| <input type="radio"/> Artificial Heart Valve | <input type="radio"/> Heart Murmur | <input type="radio"/> Sickle Cell Disease |
| <input type="radio"/> Asthma | <input type="radio"/> Heart Surgery | <input type="radio"/> Sinus Problems |
| <input type="radio"/> Blood Transfusion | <input type="radio"/> Hemophilia | <input type="radio"/> Thyroid Problems |
| <input type="radio"/> Cancer | <input type="radio"/> Hepatitis A | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Chemotherapy | <input type="radio"/> Hepatitis B | <input type="radio"/> Ulcers |
| <input type="radio"/> Colitis | <input type="radio"/> Hepatitis C | |
| <input type="radio"/> Congenital Heart Defect | <input type="radio"/> High Blood Pressure | |
| <input type="radio"/> Diabetes | <input type="radio"/> Joint Replacement | |
| <input type="radio"/> Difficulty Breathing | <input type="radio"/> Kidney Problems | |
| <input type="radio"/> Drug Abuse | <input type="radio"/> Liver Disease | |
| <input type="radio"/> Emphysema | <input type="radio"/> Low Blood Pressure | |
| <input type="radio"/> Epilepsy | <input type="radio"/> Mitral Valve Prolapse | |
| <input type="radio"/> Facial Surgery | <input type="radio"/> Pace Maker | |

Nearest relative not living with you:

Name : _____ Relationship: _____

Address: _____ Phone : _____

I understand that the information that 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 it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date: _____



Patient Name : _____ Date of Birth : _____

DENTAL HISTORY

How may we help you today? _____

Your current dental health is: Good Fair Poor

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain Yes No

Have you ever had gum treatment? Yes No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) Yes No

Are you under stress? (New job, Moving, Relationships) Yes No

Do you like your smile? Yes No

Is there anything you would like to change about your smile? Yes No

Are you happy with the color of your teeth? Yes No

Do your gums bleed? Yes No

How many times a do you: Floss / Week? Brush / Day?

Have you lost any teeth? Yes No

Have you ever had a serious/difficult problem with any previous dental work? Yes No

Have you ever had any unfavorable dental experiences? Yes No

When was your last dental cleaning? _____

When was your last dental visit? _____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

Here at **Ace Family Dental Care**, we offer a wide variety of services to enhance and keep your smile healthy and beautiful. Please select any services below you would like our friendly staff to discuss with you during your visit.

In House Teeth Whitening Veneers / Lumineers Invisalign

Six Month Smiles Cosmetic Braces Smile Makeover Bonding

Sealants Crown and Bridge Implant / Implant Crowns

Partial / Dentures Night / Sport Guards Snap-On Smile



Patient Name : _____ Date of Birth : _____

FINANCIAL AGREEMENT

- For my convenience, this office may release my information to my insurance company and receive payment directly from them.
- I understand that I am responsible for my estimated portion of the treatment fees at the time that treatment is delivered.
- I understand that my dental insurance benefits are one form of payment that I am providing to this dental practice and that payment for the total cost of services delivered to me is ultimately my responsibility. This practice will make efforts to help me secure optimal reimbursement from my insurance plan. However, if the insurance carrier does not pay as expected, I am ultimately responsible for all fees charged.
- I understand that, due to the complexity of dental diagnosis, treatment plans sometimes change. I will be responsible for payment for the care that is actually delivered to me.
- In the case of returned checks or any other reversal of payment methods that I have provided to the practice, my account will be subject to a **\$30** processing fee.
- If I allow my account to become severely delinquent in payments, causing the practice to enlist the assistance of a collections agency, I agree to pay all related fees and court costs.
- Accounts not paid within **90 days** are subject to a **1.5%** monthly finance charge.
- Any unpaid insurance balance is assumed to be patient financial responsibility.

Signature : _____ Date : _____

NOTICE OF PRIVACY POLICIES

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities and healthcare operations. I also understand that I have the right to revoke permission.

Signature : _____ Date : _____

MISSED APPOINTMENTS

I understand that this practice requires at least **48 hours** advance notice to cancel or reschedule my appointment. I also understand that, in the case that I miss an appointment, providing no or late (failing to inform the office at least **48 hours** in advance) cancellation, my account will be subject to a **\$25** charge.

Signature : _____ Date : _____

CONSENT OF SERVICES

I understand that the information that I have given is correct to the best of my knowledge. I hereby authorize the Dentist or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. I agree to be responsible for payment of all services rendered to me or my dependents. I understand payment is due at the time of service.

Signature : _____ Date : _____