Financial Information

The following information pertains to the individual financially responsible for the patient's treatment:

First Name: _____ Middle Initial: _____ Last Name: _____

Preferred Name: _____ ☐ Male ☐ Female Relationship to Patient: _____

Date of Birth: _____ Social Security Number: _____ Marital Status: _____

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

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email Address: _____

_____ (Please initial): I authorize the use of my mobile phone number (listed above) to receive scheduling and billing messages. I agree to update Canyon Gate Dental if my mobile number changes.

Insurance Information

Subscriber Name: _____ Date of Birth: _____ Employer Name: _____

Insurance Company: _____ Subscriber SSN or ID#: _____ Insurance Group #: _____

Secondary Insurance Information

Subscriber Name: _____ Date of Birth: _____ Employer Name: _____

Insurance Company: _____ Subscriber SSN or ID#: _____ Insurance Group #: _____

Financial Policies

Our mission is to deliver the finest, most cost-effective dental treatment available. Following examination and diagnosis, the doctor will advise you of our plan for treatment. We will make you aware of the fees for such treatment. Fee estimates for dental care can only be extended for a period of six months from the date of treatment diagnosis.

Whether treatment is scheduled, walk-in emergency, or otherwise, **payment is due at the time any services are rendered**. For your convenience we accept cash, personal check, Visa, MasterCard, Discover, and American Express. We also offer convenient payment options through CareCredit.

Insurance benefits are determined by your employer, not your dentist. Any deductible or estimated co-payment amount will be due at the time of treatment. Insurance is not a guarantee of payment; insurance companies may not pay for all your costs. Your insurance policy is a contract between you and your insurer. **You are responsible for any charges not paid by insurance**. As a courtesy we will be glad to file your claims for you, provided we have complete and accurate insurance information. **You will be expected to pay for services rendered if the office is unable to verify your insurance information prior to treatment**.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding 60 days from the date of service unless previously written financial arrangements are satisfied.

Should your account be turned over for collection, the undersigned agrees to pay all costs to collect the debt, including, but not limited to, interest in the amount of 18% per annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party debt collection agency.

We reserve the right to charge and collect fees for broken appointments. We consider an appointment confirmed once the appointment is scheduled. **A charge of $50 per scheduled hour may be posted to your account if an appointment is cancelled without a 24 hour advance notice** (48 hour advance notice in the case of Saturday appointments).

I, the undersigned, authorize payment of the dental benefits otherwise payable to me, directly to Canyon Gate Dental.

I have read and understand these financial policies.

Signature of Responsible Party: _____ Date: _____

Patient Information

Personal Information

First Name: _____ Middle Initial: _____ Last Name: _____

Preferred Name: _____ ☐ Male ☐ Female Date of Birth: _____ Marital Status: _____

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

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Primary Contact Number: ☐ Cell ☐ Home ☐ Work Can we use your work phone number to contact you? ☐ Yes ☐ No

Email Address: _____

Emergency Contact: _____ Phone: _____ Relationship to Patient: _____

How did you hear about Canyon Gate Dental?

☐ Google ☐ Facebook ☐ Phone Book ☐ Referral* ☐ Insurance Provider List ☐ Other: _____

*Whom may we thank for referring you? _____

Dental Information

Reason for today's visit: _____

Are you in pain right now? ☐ Yes ☐ No If so, please describe: _____

Do you have dental problems right now? ☐ Yes ☐ No If so, please describe: _____

Previous Dentist: _____ City, State of previous office: _____

Reason for switching: _____ How long since last dental visit? _____

Do you like your smile? ☐ Yes ☐ No If not, what would you change? _____

What are your expectations of a good dentist? _____

What do you dislike about visiting the dentist? _____

Are there any obstacles that would prevent you from attaining excellent dental health?

☐ I see no obstacles ☐ Poor dental hygiene ☐ Fear because of past experiences ☐ Time away from work or other obligations

☐ Fear of pain ☐ Cost of treatment ☐ Other: _____

Do you have any of the following conditions?	Y	N		Y	N		Y	N		Y	N
Tobacco use			Swollen or tender gums			Sensitivity to cold			Dry mouth		
Blisters on lips or mouth			Bleeding gums			Teeth grinding			Biting sensitivity		
Bad breath			Food traps			Jaw joint pain or clicking			Braces		
Broken teeth			Biting pain			Missing teeth			Mouth sores		

How comfortable are you with dental treatment?	(very anxious)	**1**	**2**	**3**	**4**	**5**	(comfortable)
How comfortable is your mouth	(painful)	**1**	**2**	**3**	**4**	**5**	(comfortable)
How healthy is your mouth in your opinion?	(very unhealthy)	**1**	**2**	**3**	**4**	**5**	(very healthy)
How frequently do you floss?	(never)	**1**	**2**	**3**	**4**	**5**	(daily)
How satisfied are you with the appearance of your teeth?	(unsatisfied)	**1**	**2**	**3**	**4**	**5**	(very satisfied)
How interested are you in whitening your teeth?	(not interested)	**1**	**2**	**3**	**4**	**5**	(very interested)
How important is keeping your teeth for a lifetime?	(unimportant)	**1**	**2**	**3**	**4**	**5**	(very important)
How important has dental care been for you?	(unimportant)	**1**	**2**	**3**	**4**	**5**	(very important)
In the past have you followed treatment recommendations?	(never)	**1**	**2**	**3**	**4**	**5**	(always)

Medical History

Health problems you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive. We take your health seriously at Canyon Gate Dental and thank you for answering the following questions:

Patient name: _____ Date of birth: _____ Date of last physician visit: _____

Are you under a physician's care now? ☐ **Yes** ☐ **No** Please explain: _____

Physician's name and phone number: _____

List the names and purposes of any medications you take, including birth control: _____

_____

_____ (continue on back)

List any hospitalizations or major surgeries (include dates): _____

_____

Do you require antibiotic prophylaxis for any heart condition or artificial joint? ☐ **Yes** ☐ **No** ☐ **Not sure**

Have you ever taken bisphosphonates (Fosamax, Actonel, Boniva, Zometa, Aredia, etc.)? ☐ **Yes** ☐ **No** ☐ **Not sure**

Have you ever taken Phen-Fen or similar apetite suppressants ☐ **Yes** ☐ **No**

Do you have a history of:	Y	N		Y	N		Y	N		Y	N
Heart Disorder			Shortness of Breath			Asthma			Tumors or Growths		
Heart Murmur			Blood Disorder			Tuberculosis			Chemotherapy		
High Blood Pressure			Rheumatism			Psychiatric Disorders			Radiation Treatment		
Low Blood Pressure			Arthritis			Epilepsy or Seizures			Ulcers or Stomach Problems		
Pace Maker/Heart Surgery			Hives or Rash			Psychiatric Care			Unexplained Weight Loss/Gain		
Heart Attack			Bleeding/Bruising Easily			Headaches or Migraines			Thyroid Disease		
Chest Pain			HIV Positive/AIDS			Drug Use/Addiction			Glaucoma		
Stroke/TIA			Venereal Disease			Pain Killer Addiction			Fainting or Dizziness		
Mitral Valve Prolapse			Hepatitis (Type:)			Alcoholism			Diabetes (Type:)		
Artificial Heart Valve			Liver Disease			Eating Disorders			Kidney Disease		
Rheumatic Fever			Immune System Disorders			Use of Tobacco Products			Herpes/Cold Sores/Fever Blisters		
Congenital Heart Lesion			Respiratory Problems			Methamphetamine Use			Artificial Hip, Knee or other Joint		
Feet/Ankle Swelling			Emphysema			Cancer (Type:)			Head Injury		

Additional notes or conditions not listed above: _____

_____

Women	Y	N		Y	N
Are you pregnant (or do you think you might be)?			Are you nursing?		
Estimated Delivery Date: / /			Are you taking any birth control prescriptions?		

NOTE: Antibiotics (such as penicillin, Amoxicillin, Clindamycin, etc.) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

Are you allergic to any of the following materials/medicines?

☐ I have no known allergies ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs

☐ Other: _____

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 the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, parent, or guardian: _____ Date: _____