Welcome to our Practice!

PATIENT INFORMATION ❏ Mr. ❏ Mrs. ❏ Ms. ❏ Dr. ❏ Child ❏ Male ❏ Female

First Name_______________________________ M.I._____ Last Name ___________________________ Nickname ______________

Birth Date__________ Age____ Soc. Sec. # ______________ E-mail: ____

Street____ Apt. _____ City __________________________ State______ Zip__________

Home # ___________________ Cell# ____________________ Have you ever been a patient of our practice? ❏ Yes ❏ No

Referred By: _________________________________ Has a family member ever been a patient of our practice? ❏ Yes ❏ No

In case of emergency please contact - Name: ____Ph. _____________________
Employer Bus. Ph.___________________ Relationship: _________________

PERSON RESPONSIBLE FOR ACCOUNT

❏ Self (If self, skip this section) ❏ Spouse ❏ Father ❏ Mother ❏ Other Relationship: ________________________________

Name: _____________________________ S.S.#_______________ Birth Date: ________ Age ____ Ph# _______________

Street ______________________________________ Apt._______ City___________________ State ____ Zip______________

Email _______________________________ ________ Ph # __________________ Employer Bus. Ph# __________________

SPOUSE OR SIGNIFICANT OTHERS INFORMATION (***IF DIFFERENT THAN ABOVE*****)**

Name ____ Relation ______________S.S.# ________________Birth Date __________

Street __________________________________ _____ Apt._______ City__________________ State ____ Zip______________

Email ______________________________ _________ Ph # ___________________ Employer Bus. Ph# __________________

INSURANCE INFORMATION ***Please answer questions below for patient***

Student: . . . . ❏ Full Time ❏ Part Time Marital Status: . ❏ Married ❏ Divorced ❏ Widow ❏ Single

School Name -City-State____

Employed: . . . . .❏ Full Time ❏ Part Time ❏ Retired ❏ Not Do You have Dental Insurance? ❏ Yes ❏ No

DENTAL INSURANCE PLAN INFORMATION

Employer ______________________________ __________________________________ Bus. Ph # ________________________

Bus. Address ____

Ins. Co. Name____ Tel.# _______________________________

Street ____________________________________ City________________________ State _______ Zip______________

Group # _______________________ Policy Holders Name ____ Sex: ❏ M ❏ F

ID # ___________________ Policy Holders ph# ________________ Email ____

Date of birth of Policy Holder ______________ SS # ____________________ Relationship to patient: ______________________

DENTAL INFORMATION

Reason for today's visit: Are you in pain? ❑ Yes ❑ No For How Long ____

Please indicate any of the following problems by checking off the corresponding box:

❑ Discomfort, clicking, or popping in jaw ❑ Lost / broken filling(s) ❑ Stained teeth ❑ Difficulty closing jaw

❑ Red, swollen, or bleeding gums ❑ Gum disease ❑ Locking jaw ❑ Difficulty opening jaw

❑ Do you have or use a dental appliance ❑ Ringing in ears ❑ Bad breath ❑ Loose / shifting teeth

❑ Blisters/sores in or around the mouth ❑ Burning tongue / lips ❑ Toothache ❑ Broken / chipped tooth

❑ Recent infections or sore throat ❑ Teeth grinding / clenching ❑Are you prone to cold sores

❑ Swelling / lumps in mouth ❑ Prolonged bleeding from an injury / extraction ❑ Food caught between teeth

Are your teeth are sensitive to: ❑ Hot ❑ Cold ❑ Sweets ❑ Biting

Last dental exam_____________ Last dental x–rays ____________Times a day you brush? ____Times a week you floss? ___

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) Would you like whiter teeth? ❑ Yes ❑ No

What type of toothbrush bristles do you use? ❑ Soft ❑ Medium ❑ Hard ❑ Not sure

MEDICAL INFORMATION

Are you in good health? ❑ Yes ❑ No Are you under the care of a physician? ❑ Yes ❑ No

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ❑ Yes ❑ No

Have you had any illness, operations, or been hospitalized in the past five years? ❑ Yes ❑ No

If yes what for: ____ When ? ___________________________

Do you have, or have you had, any of the following diseases, medical conditions, or procedures? *Please check all that apply*

❑ High blood pressure ❑ Low blood pressure ❑ Mitral valve prolapse ❑ Heart murmur ❑Rheumatic fever

❑ Chest pain / Angina ❑ Heart attack(s) ❑ Irregular heart beat ❑ Pacemaker ❑ Heart surgery ❑ Damaged heart valve

❑ Pneumonia / Bronchitis / Chronic cough ❑ Chronic fatigue / Night sweats ❑ Trouble climbing 1-2 flights of stairs

❑ Anemia ❑ HIV / AIDS ❑ Mental health problems ❑ Problems with immune system *(possibly from med./surg.)*

❑ Delay in healing ❑ Hay fever / Sinus problems ❑ Snoring ❑ Sleep apnea / CPAP ❑ Respiratory problems

❑ Tuberculosis ❑ Emphysema ❑ Asthma ❑ Do you smoke If so, # packs a day _____ ❑ Do you use chewing tobacco

❑ A history of drug or alcohol abuse ❑A history anorexia/bulimia ❑ Abnormal bleeding ❑ Bleeding tendency

❑ Blood transfusion ❑ Blood disorder ❑ Bruise easily ❑ Eye disease /Glaucoma ❑ Jaundice /Liver disease ❑ Hepatitis

❑ Gallbladder trouble ❑ Fainting spells ❑ Convulsions / Epilepsy ❑ Stroke ❑ Thyroid trouble ❑ Diabetes

❑ Are you on dialysis ❑ Kidney trouble ❑ Contagious diseases ❑Infectious mononucleosis ❑ Low blood sugar

❑ Swollen ankles ❑ Arthritis /Joint disease ❑ Prosthetic implant ❑ Joint replacement ❑ Stomach ulcers ❑ Osteonecrosis

❑Osteoporosis /Osteopenia ❑ Tumor or growth ❑ Cancer / Radiation / Chemotherapy

MEDICATION & ALLERGIES

Are you now taking: ❑ Blood thinners (Coumadin, Plavix, Aspirin, etc...)

❑ Are you taking, or have you ever taken, any bone density meds. or bisphosphonates, such as Fosamax, Boniva, Actonel, IV Zometa, Reclast, Xgeva, Prolia, or Aredia within the past 12 years.

Are you allergic to, or had a reaction to:

❑ Penicillin ❑ Lidocaine or other anesthetic ❑ Amoxicillin ❑ Codeine or other narcotics ❑ Latex

Please list any other medication or antibiotic you are allergic to:	***Please list any allergies other than drug allergies:***

Please list any medication(s) you are taking (including natural, herbal, or homeopathic products)

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Please type below any other information you would like the Dentist to be aware of:

Questions below for women only

Women please note: *antibiotics (such as penicillin) may alter the effectiveness of birth control pills.*

Consult your physician / gynecologist for assistance regarding additional methods of birth control.

1) Is there a possibility of pregnancy? ❑ Yes ❑ No 2) Expected delivery date: ________________

3) Are you nursing? ❑ Yes ❑ No 4) Are you taking birth control pills: ❑ Yes ❑ No

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any member of the staff responsible for any errors or omissions that I have made in the completion of this form. I agree that all information I provided is true and correct.

X____X____________________

Signature of patient (Parent or Guardian of Minor) Date

If you do have dental/medical insurance we will gladly submit you treatment/charges to you insurance company. However, it is your responsibility to complete the identifying information on this form and keep us updated with any insurance changes. Some insurance companies pay fixed allowances for procedures and other pay a percentage of the charges. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by your insurance company.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to Dr. Craig H. Etts and any of his Associate Dentists otherwise payable to me. A photocopy of this assignment shall be considered as effective and valid as the original.

X____X____________________

Signature of patient (Parent or Guardian oif Minor) Date

If the insurance company sends payment directly to me I agree to endorse the back of the check over to Dr. Craig H. Etts and mail or deliver to the office towards payment of treatment rendered.

X____X____________________

Signature of patient (Parent or Guardian of Minor) Date

Release of Information & Consent for Treatment

All information provided herein is true and correct. I wish to receive treatment at the dental office of Dr. Craig H. Etts. I permit his staff and all other persons caring for me to treatment in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to Dr. Craig H. Etts and his staff and associates to release information, verbal and written, contained in my dental record and other related information, to my insurance company, and all other persons as it related to my treatment. I understand that this information is sometimes sent via mail, email and fax.

This signature authorizes Dr. Craig H. Etts and his staff and associates to obtain/or release dental records and/or professional information from my Dentist or other medical professional as it relates to my treatment.

X____X____________________

Signature of patient (Parent or Guardian of Minor) Date

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. In addition, I hereby consent to the use and disclosure of my personal health information for the purpose of treatment, payment and health care operations.

X____X____________________

Signature of patient (Parent or Guardian of Minor) Date

I agree to pay C. H. Etts, DDS, PA for the services provided to me or my dependants. If any insurance carrier requires additional information I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. I acknowledge responsibility for any and all account balances. I understand that if I default on payment of my account balance, that my account can be turned over to a collection service and I can be charged, interest, late fees, attorney fees, including costs of a collection agency and associated fees if turned over to an agency and court costs in addition to the remaining balance that is due.

In an effort to contain the ever-rising costs of healthcare our office charges a rebilling fee on unpaid balance over sixty (60) days old at the rate of 1.5% (18% per annum). Also for patients needing a payment plan a $25 late fee will be assessed on payments not received by the last day of each month. We feel this will help offset the costs of rebilling patient thus preventing the need to raise fees on all dental services. I also understand that I can be assessed a $75 no-show or late cancellation fee for appointments that I fail to show-up to or did not give a 48 hour cancellation notice.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of C. H. Etts, DDS, PA, and/or its affiliate or subsidiaries.

X____X____________________

Signature of patient (Parent or Guardian of Minor) Date