Date: _____

Willow Springs Dental

ABOUT YOU

_____
First Name MI Last

Preferred name: _____

Home Address: _____

_____
City State Zip

Social Security #: _____
Date of Birth: _____Age _____ □ Male □ Female
□ Single □ Married □ Divorced □ Widowed
Name of spouse: _____

CONTACT INFORMATION
Home # _____Cell#_____
Work #_____Alternate phone #_____
Email Address: _____

Your Employer: _____
Occupation: _____ How long? _____

In the event of an emergency, is there someone we can contact? □ YES □ NO
Name: _____
Relationship: _____
Phone #: _____

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

CANCELLATION POLICY

EXCEPT IN SEVERE WEATHER CONDITIONS OR IN EXTREME EMERGENCIES, A 48 HOUR NOTICE IS REQUIRED FOR CANCELLATION. OTHERWISE, PATIENTS WILL BE RESPONSIBLE FOR PAYMENT FOR THEIR APPOINTMENT, WHICH WILL BE CHARGED AT THE RATE OF $50 PER ½ HOUR.

SIGNATURE: _____

STATEMENT OF PAYMENT POLICY
Payment is required for all charges on the day of service. As a courtesy, we will bill your insurance company for their estimated portion, if we are provided with a copy of your insurance card. If we do not receive payment from your insurance company for their portion within 60 days we will send you a statement and expect payment in full from you at this time. Any balance over 90 days is subject to an 18% finance charge.

SIGNATURE: _____

DENTAL BENEFITS
Do you have dental benefits? □ YES □NO
Primary Insurance

Name of Subscriber: _____
Date of Birth: _____
Social Security or ID #: _____
Group #: _____
Insurance Co. Name: _____
Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: _____
Employer's Name: _____
Employer's Phone #: _____
Employer's Address: _____

_____
City State Zip

Secondary Insurance:

Name of Subscriber: _____
Date of Birth: _____
Social Security or ID #: _____
Group #: _____
Insurance Co. Name: _____
Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: _____
Employer's Name: _____
Employer's Phone #: _____
Employer's Address: _____

_____

INSURANCE COVERAGE
Every effort is made to provide you with the best estimate from your insurance company. In some cases, actual insurance payments are lower than the estimates given. Charges incurred are ultimately your responsibility and you will be responsible for any difference between the insurance estimate and the actual insurance payment.

SIGNATURE:_____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my insurance information, address or phone number

SIGNATURE: _____

CONTINUE TO BACK SIDE→

MEDICAL HISTORY

Have you ever had any of the following diseases or Medical problems?

Y N Anemia	**Y N Heart Disease**
Y N Angina	**Y N Heart Murmur**
Y N Anti Clott Med.	**Y N Hemophilia**
Y N Anxiety Attacks	**Y N Hepatitis**
Y N Arthritis	**Y N Herpes**
Y N Artificial Joints	**Y N High Blood Pressure**
Y N Asthma	**Y N HIV/ AIDS**
Y N Back Injury	**Y N Jaundice**
Y N Blood Disease	**Y N Kidney Disease**
Y N By Pass Surgery	**Y N Liver Disease**
Y N Cancer Therapy	**Y N Low Blood Pressure**
Y N Chemical Dependency	**Y N Nervous Disorder**
Y N Coronary Occlusion	**Y N Pacemaker**
Y N Diabetes	**Y N Prolapsed Valve**
Y N Dizziness	**Y N Psychiatric Disorder**
Y N Eating Disorder	**Y N Radiation Treatment**
Y N Epilepsy/Fainting	**Y N Respiratory Problems**
Y N Excessive Bleeding	**Y N Sinus Problems**
Y N Fainting	**Y N Stomach Problems**
Y N Frequent Headaches	**Y N Stroke**
Y N Glaucoma	**Y N Swollen Glands**
Y N Hay Fever	**Y N Thyroid Disease**
Y N Head Injuries	**Y N Tuberculosis**
Y N Heart Attack	**Y N Ulcers**

Are you allergic to any of the following?

□ Aspirin □ Codeine □ Latex □ Seasonal
□ Metals □ Penicillin □ Sulfa
□ Other Allergies _____

Physician's Name: _____
Phone #: _____ Last medical visit: _____
Are you currently under the care of a physician? □ YES □ NO
If yes, explain: _____

Do you smoke or chew tobacco? □ YES □ NO
Do you drink alcohol? □ YES □ NO How often?_____

Are you currently taking any drugs prescribed by a physician or dentist? □ YES □ NO If yes, please list: _____
_____

For women: Are you pregnant? □ YES □ NO
If yes, how many months? _____

Have you had any prior surgeries? □ YES □ NO
If yes, please list: _____

Have you had any serious medical problems in the past?
□ YES □ NO If yes, explain: _____
_____

DENTAL INFORMATION

When was your last dental visit? _____
Were X-Rays taken? □ YES □ NO
Frequency of dental visits? _____

Do you need to be pre-medicated before dental treatment?
□ YES □ NO If yes, explain: _____

Do you have any dental concerns today? □ YES □ NO
If yes, explain: _____

Have you ever had adverse effects to dental anesthetic?
□ YES □ NO If yes,
explain:_____

Have you ever experienced difficulty becoming numb?
□ YES □ NO If yes, explain:
_____

How do you feel about the appearance of your teeth?
_____

Is there anything you would change about your smile?
□ YES □ NO If yes, explain:_____

Are there any old fillings or dental work you do not like?
□ YES □ NO If yes, explain: _____

Are you concerned about bad breath? □ YES □ NO

Would you like your teeth to be straighter? □ YES □ NO

Would you like your teeth to be whiter? □ YES □ NO

Please check the box if the description applies to you:

□ **Difficulty chewing on the right**
□ **Difficulty chewing on the left**
□ **Bleeding gums**
□ **Frequent cavities**
□ **Painful facial joints**
□ **Popping/Clicking**
□ **Grinding/Clenching your teeth**
□ **Difficulty flossing**
□ **Headaches/Neck aches**
□ **Ear Aches/Ringing**

UPDATE

Date: _____ Date: _____
Patient: _____ Patient: _____
Office:_____ Office: _____

Date: _____ Date: _____
Patient: _____ Patient: _____
Office:_____ Office: _____