Thank you for choosing us to be your dental team. Please fill out this form completely and to the best of your knowledge. If you have any concerns or questions regarding this form ask for assistance from our friendly staff.

Name:_______________________________________ Birth Date:_____________Gender: M F
Home Address: ____________________________ City: __________________ State: _____ ZIP: _______
Home Phone: _________________ Work Phone: ________________ Cell Phone: __________________
Please Check: Single _____ Married _____ Separated _____ Widowed _____ Divorced _____
Email: ____ Soc. Sec. #: _____________________
Emergency Contact: ____________________ Relation: ________________ Phone: ________________

INSURANCE INFORMATION *Please be advised we are currently NOT a Medicaid provider.*

Subscriber Name: ____ Birth Date: _____________
Soc. Sec #: ______________________ Relation to Patient:_________________________
Insurance Company: _____________________________ Member ID#: _________________
Group#: _________________ Group Name: ________________________

DENTAL HISTORY:

Previous dentist: _____________________________________ Date of Last Exam ____/____/______

	Yes	No
Are you having any dental problems that you are aware of?....................................	☐	☐
Do you have a history of gum disease?	☐	☐
Do you have any clicking, popping or discomfort in jaw joints?	☐	☐
Do you feel nervous about dental treatment?..	☐	☐
Have you ever had a bad experience in a dental office...	☐	☐
Have you ever had any complications after dental treatment?	☐	☐
Are you happy with your smile?	☐	☐
Would you like whiter teeth?	☐	☐

MEDICAL HISTORY:

Current Physician: _________________________________ Date of Last Exam: ____/____/______

	Yes	No
Are you currently under a physician's care for any reason?	☐	☐
Have you been hospitalized in the last two years for any reason?	☐	☐
Have you taken any prescription medications in the last two years?	☐	☐
Are you on a special diet? (Explain) ______________________________________	☐	☐
Do you smoke or chew tobacco? (Years) ____________ (packs per day)__________	☐	☐
Are you currently taking any vitamins, herbal supplements, or "cures"	☐	☐
Do you use recreational drugs (such as marijuana, cocaine, methamphetamine)?	☐	☐

Do you consume alcohol? *Daily* *Weekly* *Within last 24 hours* *Socially*

Do you have any drug/substance allergies? (list) ____

Please list current medications:

____

Preferred Pharmacy: _______________________________________ Phone: ____________________

MEDICAL HISTORY QUESTIONAIRE:

	Yes	No		Yes	No		Yes	No
Heart Disease	☐	☐	Artificial Joints	☐	☐	Emphysema	☐	☐
Irregular Heartbeat	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐
Angina/Chest Pains	☐	☐	Excessive Bleeding	☐	☐	Cancer	☐	☐
Heart Attack	☐	☐	Sickle Cell Disease	☐	☐	Radiation Treatments	☐	☐
Artificial Heart Valve	☐	☐	Blood Disorder	☐	☐	Chemotherapy	☐	☐
Cardiac Pace Maker	☐	☐	Leukemia	☐	☐	Stomach Ulcers	☐	☐
Heart Surgery	☐	☐	Swelling of Limbs	☐	☐	Recent Weight Change	☐	☐
High Blood Pressure	☐	☐	Lung Disease	☐	☐	Diabetes	☐	☐
Kidney Disease	☐	☐	Shortness of Breath	☐	☐	Autoimmune Disease	☐	☐
HIV	☐	☐	Frequent Cough	☐	☐	Liver Disease	☐	☐
Drug Addiction	☐	☐	Asthma	☐	☐	Hep A, B, or C	☐	☐
Seasonal Allergies	☐	☐	Epilepsy or Seizures	☐	☐	Psychiatric Care	☐	☐

Woman Only	Oral Contraceptive: Y N	Nursing: Y N	Pregnant: Y N	Due Date:___________

I have answered every question to the best of my knowledge. I understand improper information can be dangerous to my safety during dental treatment. I consent to complete oral examination and necessary x-rays.

Signature: ____ Date: ________________

Dental Care Providers of America
3715 Washington Road
Kenosha, WI 53144

FINANCIAL AGREEMENT

It is our goal for patients to understand their treatment needs as well as the cost associated with those needs prior to the beginning of treatment. The estimated patient portion is due at the time of treatment. We try to make dental care affordable to everyone, so we offer the following:

- Flexible payment plans through CareCredit®. Approval of CareCredit® must be received prior to treatment date.
- Cash, Check, & most major credit cards.

As a courtesy to you we will process all insurance claims. We completely understand insurance can be hard to comprehend but with the information you provide we can offer some assistance with interpreting and estimating your benefits. Please keep in mind that your insurance company makes the final determination once treatment is completed and the claim is submitted. We highly recommend pre-authorizations for any treatment over $300.00. Your insurance is a contract between you and your insurance company; therefore, all charges are your responsibility in the event insurance does not pay for services.

Appointment times have been specifically reserved for you. We reserve the right to charge a fee of $75.00 for all canceled or missed appointments without 48 hours notice.

- All insurance benefits are payable to the dental office, and I agree to release any information necessary for the dental office to process claims.
- I realize I am financially responsible for all charges incurred, regardless of insurance coverage. I am aware past due accounts will be sent to a third-party collection agency and further charges may accrue. I am responsible for all collection costs incurred by the dental office and on a returned check, a fee of$30.00.
- I am aware Dental Care Providers of America requires a 48-hour advance to reschedule appointments, with the exception of individual circumstances.

____

Patient/Legal Guardian Signature Date

____

Print Name

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

____

____

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