Goodman Dental Center
Confidential Patient Information

Date:_____

PATIENT INFORMATION (Please Print Legibly)

Name:_____ SS#:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone (Home):_____ (Work):_____

(Cell):_____ **EMAIL:**_____

Birth Date:_____ Sex:_____ Marital Status:_____ Spouse Name:_____

Employer:_____ Occupation:_____

Referred by:_____

PERSON RESPONSIBLE FOR ACCOUNT (Write "Self" If Same as Above)

Name:_____ SS#:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone (Home):_____ (Work):_____

(Cell):_____ **EMAIL:**_____

Birth Date:_____ Sex:_____ Marital Status:_____ Spouse Name:_____

Employer:_____ Occupation:_____

Relationship to Patient:_____

DENTAL INSURANCE INFORMATION

Primary Insurance Co:_____ Telephone:_____

Insurance Co. Address:_____

Subscriber Name:_____ Relationship to Patient:_____

Birth Date:_____ SS#:_____ ID#:_____

Employer:_____ Group #:_____

Secondary Insurance Co:_____ Telephone:_____

Insurance Co. Address:_____

Subscriber Name:_____ Relationship to Patient:_____

Birth Date:_____ SS#:_____ ID#:_____

Employer:_____ Group #:_____

I authorize GOODMAN DENTAL CENTER to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents. I authorize payment of dental benefits otherwise payable to me, directly to GOODMAN DENTAL CENTER. I agree to be responsible for all charges for dental services and materials not paid by my dental plan.
I understand that payment is my obligation regardless of insurance or any other third-party involvement.

SIGNATURE:	DATE:

Patient Name:_____

HEALTH INFORMATION

Physician Name: _____ Phone #:_____ Last Exam:_____

Pref. Pharmacy: _____ Cross Streets:_____

YES	NO	
❑	❑	Have you been hospitalized within the past 2 years? For what:_____
❑	❑	Are you currently being treated by a physician? For what:_____
❑	❑	Are you currently taking any medicines or drugs? What:_____
❑	❑	Have you ever received counseling for excessive use of alcohol and/or prescription drugs?
❑	❑	Do you use any forms of tobacco? What/frequency:_____
❑	❑	Have you ever had a joint replacement? What joint and when:_____
❑	❑	Are you allergic to any drugs/metals What:_____
❑	❑	Have you ever had a skin rash or other reaction to metal jewelry? To what:_____
❑	❑	Do you bleed excessively upon injury?
❑	❑	Are you pregnant? How many months along?_____
❑	❑	Have you ever been involved with dental/medical legal activity?
❑	❑	Do you snore or ever been told you do?
❑	❑	Do you feel excessively sleepy during the day?
❑	❑	Have you had weight gain and found it difficult to lose?
❑	❑	Have you been diagnosed with sleep apnea?
❑	❑	Do you use a CPAP (continuous positive airway pressure)?

CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE HAD:

A. AIDS	F. Epilepsy	K. High Blood Pressure	P. Rheumatic Fever
B. Arthritis	G. Glaucoma	L. Jaundice	Q. STD
C. Asthma	H. Heart Murmur	M. Kidney Problems	R. Stroke
D. Cancer	I. Heart Problem *	N. Low Blood Pressure	S. Tuberculosis
E. Diabetes	J. Hepatitis A / B / C	O. Nervous Breakdown/ Psychiatric Therapy	T. Other Diseases *

***If you circled either I or T, describe condition**:_____

How would you rate the condition of your mouth:

❑-Excellent ❑-Good ❑-Fair ❑-Poor

Date of most recent dental exam:_____ Date of most recent dental x-rays:_____

I routinely see my dentist every: ❑3 months ❑4 months ❑6 months ❑12 months ❑Not routinely

SIGNATURE:	DATE:
REVIEWED BY (office use only):	DATE:

Patient Name:_____

What is your immediate concern:_____

Are you fearful of dental treatment? ❑ Yes ❑ No

Personal History – Check all that apply:

- ❑ Had an unfavorable dental experience
- ❑ Had trouble getting numb
- ❑ Had/have braces/orthodontic treatment
- ❑ Had your bite adjusted
- ❑ Had any teeth removed
- ❑ Had complication from past dental treatment
- ❑ Had any reactions to local anesthetic

Smile Characteristics – Check all that apply:

- ❑ Are you **unhappy** with your smile?
- ❑ Is there anything about the appearance of your teeth that you would like to change?
- ❑ Have you ever whitened (bleached) your teeth?
- ❑ Have you felt uncomfortable or self conscious about the appearance of your teeth?
- ❑ Have you been disappointed with the appearance of previous dental work?

Bite and Jaw Joint – Check all that apply:

- ❑ Problems with your jaw joint
- ❑ Teeth crowding or developing spaces
- ❑ Do you clench your teeth
- ❑ Problems chewing
- ❑ Do you chew ice or bite your nails
- ❑ Do you wear or have worn a bite appliance

Tooth Structure – Check all that apply:

- ❑ Cavities within past 3 years
- ❑ Amount of saliva seems too little/difficulty swallowing
- ❑ Sensitivity to hot, cold, biting or sweets
- ❑ Avoid brushing any part of your mouth
- ❑ Food gets caught between any teeth

Gum and Bone – Check all that apply:

- ❑ Gums bleed when brushing or flossing
- ❑ Noticed an unpleasant taste or odor in your mouth
- ❑ Experience gum recession
- ❑ Experience a burning sensation in your mouth
- ❑ History of periodontal disease in your family
- ❑ Previously treated for gum disease
- ❑ Teeth become loose on their own

PERSON TO BE CONTACTED IN CASE OF EMERGENCY

Name:_____ Relationship:_____

Address:_____

Telephone (Home):_____ (Work):_____

(Cell):_____

SIGNATURE:	DATE:
REVIEWED BY (office use only):	DATE:

Cancellation Policy

A $50 fee will be charged for any no shows or changes to appointments without at least 24 hours prior notice.

Consent for Services and Financial Policy

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, unless previous payment arrangements have been made. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patient for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements must be paid for in full at the time of service unless other arrangement are made.

Financial responsibility: I further agree to pay all finance charges, collection cost, attorney's fees, and any other cost that may be incurred to enforce collection of any amount outstanding.

I understand that any treatment estimate for dental care can only be extended for a period of 6 months from the date of the patient examination.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

PRINTED NAME (Patient and/or Responsible Party):	
SIGNATURE:	DATE: