WELCOME TO CASELLE DENTAL, LLC - TELL US ABOUT YOURSELF

Patient's Name_____ Date_____
Last First MI

Preferred Name_____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Address_____City _____ State _____Zip_____

Social Security # _____Birth Date_____ E-mail_____

Phone (Home) _____ (Work) _____ Ext_____Cell Phone_____

Employer Name_____ Occupation_____

Address: _____
Street City State Zip

Preferred contact for appointment confirmation: Home Phone ☐ Cell Phone ☐ Email ☐ Text ☐ Work Phone ☐

Emergency Contact: Name: _____ Phone: _____

◆ Person Responsible for Payment (if other than patient)

Name: _____☐ Male ☐ Female ☐ Married ☐ Single ☐ Other_____

Social Security # _____Birth Date_____ E-Mail_____

Phone (Home)_____ (Work)_____ Ext:_____ Cell Phone_____

Address_____City_____ State_____ Zip_____

Employer Name_____ Occupation_____

Address:_____
Street City State Zip Code

◆ Insurance – Primary

Name of Insured_____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date _____ ID # _____ Group #_____

Insured's Address_____City_____State_____Zip_____

Insured's Employer Name_____

Address_____

Patient's relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address_____

_____

◆ Insurance – Secondary

Name of Insured_____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date_____ ID # _____Group #_____

Insured's Address_____City_____State_____Zip_____

Insured's Employer Name_____

Address_____

Patient's relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address_____

_____

PATIENT_____**DOB**_____

Medical History

Do you have or have you ever had any of the following? Please check those that apply.

- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints _____
- ☐ Asthma
- ☐ Blood Transfusion _____
- ☐ Cancer _____
- ☐ Chemotherapy
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Facial Surgery
- ☐ Fainting
- ☐ Frequent headaches
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis – **Type** _____
- ☐ High Blood Pressure
- ☐ HIV / AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Migraines
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Psychiatric Problems
- ☐ Radiation Therapy
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sexually Transmitted Disease
  Type_____
- ☐ Shingles
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Persistent Cough
- ☐ Tuberculosis
  Date_____
- ☐ Cough that produces blood
- ☐ Been exposed to anyone with Tuberculosis
- ☐ Ulcers

Allergies To Medications
- ☐ Penicillin Allergy
- ☐ _____
- ☐ _____

Women only:
- ☐ Pregnancy
  Due Date_____
- Are You Nursing?____
- Are Taking Birth Control Pills?_____

- Do you use tobacco (smoking, snuff or chew)? ☐ Yes ☐ No If yes, how much?_____
- Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how much alcohol do you typically drink in a week? _____
- Do your gums bleed when you brush or floss? ☐ Yes ☐ No How often do you brush?: _____ How often do you floss?:_____
- Are your teeth sensitive to cold, hot, sweets or pressure? ☐ Yes ☐ No • Do you brux or grind your teeth? ☐ Yes ☐ No
- Name of your Primary Care Physician_____ Phone_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Do you have any health problems that need further clarification or were not listed above? ☐ Yes ☐ No
  If yes, please explain:_____
- List any medications you are taking **(if none write NONE)**: _____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct.
If I ever have any change in my health, I agree to inform the doctor at the next appointment.

▶ _____Reviewed by ▶ _____ Date: _____
Signature of patient, parent or guardian

How did you hear about our office? ☐ Another patient ☐ Internet ☐ Insurance Company ☐ Dental Office ☐ Verizon Yellow Pages
☐ Community Yellow Pages ☐ Newspaper ☐ Work ☐ Other_____
Name of person or office referring you to our practice_____

- Date of Last Dental Visit_____ Reason for this visit_____
- If you could change one thing about your smile what would it be?_____
- Why did you leave your last dentist? _____
- What did you like most about any dentist you have ever seen? _____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No If yes, please explain:

_____

Financial Policy & Authorizations

- As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patient for the costs incurred in their care and the 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 at the time services are performed. We accept MasterCard, Visa, American Express, Discover, cash, and checks. If you are in need of an extended finance option, we work with CareCredit, which offers short term interest free programs or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit. Ask for details.

- If you have a Dental Plan please know that it is designed to help you pay for a portion of the cost of your dental care. Therefore, patients who have dental insurance should understand that all dental services provided are charged directly to the patient and that he or she is personally responsible for payment of all dental services. Our office will prepare insurance forms and assist in obtaining payment from your insurance company on your behalf and will credit any such payments to your account. Please understand our dental office cannot render services on the assumption that our charges will be paid by your insurance company.

- Insurance eligibility and benefits quoted are not a guarantee, they are subject to change. We will provide you with an estimate of your co-payments and deductible based on your insurance coverage which is payable at the time of your visit. This ESTIMATE IS NOT A GUARANTEE of the final amount of benefits to be paid by your insurance company. The final amount of benefits to be paid will be determined by your insurance company only after they receive the dental claim. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for all of your dental care. It is only meant to assist you.

- The amount your plan pays is determined by the agreement negotiated by your employer with the insurer and by how much your employer contributes to the plan.

- As a service to you, we will submit your dental claims to your insurance company. Keep in mind that dental plans are designed to share in the cost of your dental care, not to completely pay for those costs. Please ask for “Why Doesn’t My Insurance Pay for This?” pamphlet at the front desk which will answer any other questions you may have about dental insurance

- I further agree to pay for all services rendered regardless of anticipated insurance benefits within 30 days of the date of service and agree to pay all reasonable attorney fees or collection costs associated with non-payment of an account balance.

- A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days regardless of anticipated insurance payments.

- I authorize the release of any information including the diagnosis and records of treatment or examination rendered to either myself or a dependent to my insurance company and/or healthcare practitioner. I authorize and request that my insurance company pay directly to the doctor insurance benefits otherwise payable to me.

- **I have read and understand the above Financial Policy and Authorizations.**

► _____ Date: _____ Relationship to Patient:_____
Signature of patient, parent or legal representative

► _____ Date: _____ Relationship to Patient:_____
Signature of person responsible for payment other than patient