Patient Information

Patient Name: _____ Date:_____
First MI Last (Preferred Name)

Gender: _____ Date of Birth: _____ Email: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Social Security Number: _____ Marital Status: _____

Emergency Contact:_____**Phone:**_____

Referral Information

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

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you been diagnosed with any of the following conditions? If so, provide a year. Check those that apply:

- ☐ AIDS
- ☐ Allergies _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints_____
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ VenerealDisease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Bisphosphonates

OTHER:

- ☐ _____

- List current medications: _____

_____

- Do you require an antibiotic premed prior to dental procedures? ☐ Yes ☐ No
  If yes, who is prescribing physician? : _____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

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 will inform the doctors at the next appointment.

_____ Date: _____
Signature of patient, parent or guardian

Financial Policy Agreement

The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. As consistent with applicable laws and the policies of the patient's applicable dental insurance or other third-party payer coverage, we require the following:

All emergency dental services and any dental services performed without previous financial arrangements must be paid for in full at the time services are rendered.

Any cost associated with treatment recommended for the patient by Dr. Culler will be reviewed prior to beginning/scheduling procedures. If the patient has insurance, an ESTIMATE will be shown to the patient and signed, showing the total ESTIMATED out of pocket cost after insurance. If the patient's insurance does not cover a procedure (or portion of procedure), the patient is responsible for paying the remaining office fee amount. Any quote given by an insurance provider is never a guarantee of coverage/payment. Balances left, if any, will be communicated to patient once the insurance payment is received (can take up to 3 weeks), and falls under the patient's responsibility.

Fee estimates for dental care can only be extended for a period of six months from the date of consultation.

Upon scheduling treatment appointments requiring a 2-hour time-frame or longer, the office will collect a $150 deposit, that will go towards treatment cost. If the patient cancels or reschedules the appointment in less than 48-hours, this balance will become a missed appointment fee, and amount will NOT go towards treatment.
If patient cancels hygiene appointment or other treatment appointments scheduled for 1.5 hours or less, with less than 48-hours advance notice, patient will be charged a non-refundable $50 late cancellation fee.

Payment for services is due at the time of treatment unless otherwise arranged with office. Any outstanding balances beyond (90) days must be paid immediately, or patient understands they may be sent to a collections agency. Our office will make every effort to collect balance before this point.

Charges for services shall be as billed unless objected to, by the patient, in writing, within the time payment is due.

Consent for Services

I authorize Dr. Culler, the hygienist, and/or assistants to perform those procedures as may be deemed necessary or advisable to maintain my dental health. This includes arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to: bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that after dental treatment, including procedures such as cleanings and fillings of all types, teeth may be sensitive both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions, so please let your clinician know if you have ever had an adverse reaction to any dental treatment.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal. Several safety measures are taken to prevent this, but it is always a risk.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past. I understand that taking the class of drugs prescribed for the prevention of osteoporosis (bisphosphonates), such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions. This also applies to any blood thinners that the patient may be taking.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party