Penniall
family dental

NEW PATIENT FORMS

*Please complete all **4 pages** to the best of your ability.*

PATIENT INFORMATION FORM	**Today's Date**
Patient Name*: First Last	I prefer to be called
Address*: Street City	State Zip
Phone #*: Cell Home	**Preferred contact method*:**
Email*:	☐ Home Phone ☐ Cell Phone ☐ Email
Date of Birth*:	**Sex*:** ☐ Male ☐ Female **Marital Status:**
Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Student ☐ Unemployed	**Occupation:**
In case of emergency, who should be notified?*	
Relationship to Patient*:	**Phone Number*:**
Do you have dental insurance?* ☐ Yes ☐ No ☐ Unsure ☐ Other *(explain)*	

RESPONSIBLE PARTY INFORMATION		
Name: First Last		**Date of Birth:**
Phone #:	**Relationship to Patient:** ☐ Self ☐ Spouse ☐ Parent ☐ Other *(explain)*	
Address: Street City	State	Zip
Social Security #:	**Drivers License #:**	**State:**

INSURANCE INFORMATION	
Employee Name: First Last	
Employer Name:	
Insurance Company:	
Group #:	**Member ID:**

HOW DID YOU HEAR ABOUT US?*
☐ Search Engine (Google, etc.) ☐ Facebook ☐ Insurance ☐ Driving By ☐ Word of Mouth ☐ Other *(explain)*
Is there someone we may thank for referring you to our office?

I give permission for the doctor or authorized staff to use x-rays, study models, and other diagnostic tools for a thorough assessment of (patient name) _____ and authorize recommended treatment, assistance, and use of anesthesia, sedation, and medication as needed. I understand the risks of anesthesia and have the right to ask for an explanation of potential complications.

Signature of Patient or Responsible Party _____ Date _____

Patient Name	Nickname	Age

MEDICAL HISTORY Please use an "X" to mark your answers to the following questions.

Do you have, or have you ever had, any of the following conditions?

	Yes	No
Heart (Cardiac)		
Pacemaker	☐	☐
Artificial Heart Valve	☐	☐
Congenital Heart Disease	☐	☐
Congestive Heart Failure	☐	☐
Heart Attack (date _____)	☐	☐
Heart Murmur	☐	☐
Stroke (date _____)	☐	☐
High or Low Blood Pressure Low	☐	☐
Autoimmune/Blood (Circulatory)		
HIV/AIDS	☐	☐
Autoimmune Disease (lupus, RA, etc.)	☐	☐
Bleeding Disorder/Blood Thinners	☐	☐
Sickle Cell Disease	☐	☐
Cancer	☐	☐
Type: _____		
Date of Diagnosis: _____		
Chemotherapy/Radiation/Surgery Surgery	☐	☐
Brain (Neurological)/Mental Health		
Anxiety	☐	☐
Depression	☐	☐
ADD/ADHD	☐	☐
Epilepsy or Seizures	☐	☐
Mental Health Disorders	☐	☐
Neurological Disorders	☐	☐
Fainting or Dizzy Spells	☐	☐
Vertigo	☐	☐
Respiratory (Breathing)		
Asthma	☐	☐
Tuberculosis	☐	☐
Sinus Trouble	☐	☐
Other		
Artificial Joints	☐	☐
Diabetes (type _____, HbA1c _____)	☐	☐
GERD	☐	☐
Hepatitis (type _____)	☐	☐
Transplant (date _____)	☐	☐
Sleep Problems (sleep apnea, snoring)	☐	☐
High Cholesterol	☐	☐
Eating Disorders	☐	☐
Osteoporosis	☐	☐

Do you have any **disease, condition, or problem that is not listed here**? If so, please explain.

Have you had any **major illnesses, surgeries, or hospitalizations in the last 5 years**? If so, please explain.

MEDICATIONS & SUBSTANCES

	Yes	No
***Have you ever premedicated prior to a dental visit?**	☐	☐
If yes, for what? _____		
What did you take? _____		
Do you **smoke tobacco**?	☐	☐
If yes, how many cigarettes/cigars per day? _____		
If yes, how many years have you been smoking? _____		
Have you thought about quitting or have you quit before?	☐	☐
Do you **chew tobacco**?	☐	☐
Do you use **vaping products**?	☐	☐
Do you use any **recreational drugs**, including **marijuana**?	☐	☐
How many **alcoholic beverages** do you have per week? _____		
Are you taking **dietary supplements, vitamins, and/or probiotics**?	☐	☐
WOMEN ONLY: Are you		
Taking **birth control pills?**	☐	☐
Pregnant? If yes, number of weeks: _____ trimester: _____	☐	☐
Nursing?	☐	☐

List all **medications, supplements, vitamins, and/or probiotics** taken **within the last 2 years**.

DRUG	PURPOSE	DRUG	PURPOSE

Please list any known **allergies or adverse reactions to medications or substances**.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient or Responsible Party _____ Date _____

Patient Name	Nickname	Age

DENTAL HISTORY

What was the **name of your previous dentist**? Where was the office located?

Why are you **changing dentists**?

- ☐ Change of residence
- ☐ Change of dental plan
- ☐ Your office is closer
- ☐ Too expensive
- ☐ My dentist retired/closed
- ☐ Unhappy
- ☐ You were recommended
- ☐ Other:

Please explain:

What is the **reason for your visit**?

☐ Check-up/Cleaning ☐ Filling(s)/Crown(s) ☐ Pain/Discomfort (if so, *where*?) ☐ Other:

Please provide details:

How long has it been since your **last dental visit**?

☐ 1-3 months ☐ 6 months ☐ 1-2 years ☐ 3+ years ☐ I've never seen a dentist ☐ Other:

How long has it been since your **last dental cleaning**?

☐ 1-3 months ☐ 6 months ☐ 1-2 years ☐ 3+ years ☐ I've never seen a dentist ☐ Other:

When was the last time you had **dental x-rays** taken?

What was done at your last dental visit?

PERSONAL HISTORY & SMILE CHARACTERISTICS

Please use an "X" to mark your answers to the following questions.	**Yes**	**No**
Do you feel **nervous** about having dental treatment?	☐	☐
If yes, please *circle* one: slightly, moderately, extremely		
Have you ever had a **bad or upsetting experience** at the dentist?	☐	☐
Have you ever had any **complications** following dental treatment?	☐	☐
Have you ever had an unfavorable **reaction to dental anesthetic**?	☐	☐
Have you ever had **trouble getting numb?**	☐	☐
Do your gums **bleed** when you brush or floss?	☐	☐
Are you aware of **sores** or irritated areas in your mouth?	☐	☐
Have you ever been treated for **periodontal disease**?	☐	☐
Do you participate in **contact sports** or **high speed sports** (skiing, motorcycles, etc)?	☐	☐
Have you had **orthodontic work** (braces, clear aligners) in the past?	☐	☐
Do you like your smile?	☐	☐

If you could change your smile, **what would you like to change**? Please mark all that apply.

- ☐ The color of my teeth/interested in bleaching
- ☐ Close spaces or restore worn and broken teeth
- ☐ The shape of my teeth
- ☐ The position or alignment of my teeth
- ☐ Other

Please specify:

To ensure your visit is a great experience, please share any **questions or concerns** you would like us to know about.

Signature of Patient or Responsible Party _____ Date _____

FINANCIAL POLICY

GENERAL POLICY

Thank you for choosing Penniall Family Dental as your dental care provider. We are committed to delivering high quality dental services and value your business. To ensure that we can continue to provide the best care to all of our patients, we have a financial policy in place that outlines payment requirements. If you have any questions about our fees or financial policy, please don't hesitate to ask.

At our practice, we prioritize providing high quality care to our patients and strive to make your experience with us as positive as possible. We base our fees on the materials we use and the time, effort, and skill required to perform your necessary treatment. We make every effort to offer competitive pricing for our services and provide treatment plan **ESTIMATES** that are **valid for 6 months**. You are **FULLY RESPONSIBLE** for any charges for the treatment rendered and any differences between the original estimate and final bill.

Preferred payment methods include **cash, check and debit**. We also accept most major credit cards. Payment for services is due at the time of treatment unless alternate arrangements have been agreed upon in advance. If you are facing temporary financial difficulties that may impact your ability to make timely payments on your account, we have **financial options** available to help you. If you have any financial concerns, please don't hesitate to contact us. We are here to assist you and address any questions or issues you may have. Thank you for your understanding and cooperation.

REGARDING INSURANCE

We can assist you with understanding your insurance coverage and costs before your treatment. While we'll submit claims on your behalf, **we can't guarantee any coverage estimates**. It's important to remember that your insurance policy is a contract between you and the insurance company, and you'll be responsible for paying for any charges not covered by insurance. If there are any changes to your insurance policy, please let us know. Our practice is committed to providing high quality treatment and our fees are in line with what's typical in our area. However, each insurance company has its own standards for determining "usual and customary" rates, so you may need to pay the full cost of treatment even if your insurance company doesn't cover it. As a special offer for our patients without dental insurance, we are pleased to offer a courtesy of 5% on credit card payments and 10% on cash or check payments.

DEPOSIT SCHEDULING POLICY

Please arrive at our office **10 minutes before** your scheduled appointment to update your patient information. If you're running late, your appointment may need to be rescheduled or canceled. We'll call or text you in advance to confirm your appointment. If you don't respond to these confirmation attempts, your appointment may be canceled.

We ask that you give us at least **48 hours notice** (excluding Fridays and weekends) for any changes to your appointment. If you don't provide sufficient notice and are unable to keep your appointment, it will be considered a **broken appointment**. We may require a **deposit before scheduling** any future appointments for existing patients who have had one broken appointment. The deposit amount is **$50** for appointments **under 1 hour** and **$100 per hour** for appointments **over 1 hour**. Deposits are applied towards treatment costs but are non-refundable if the appointment is canceled or rescheduled **without at least 48 hours advance notice**.

For patients with complex dental needs, it may be necessary to reserve a large block of our schedule. In these cases, **a deposit may be required for appointments that last more than 1.5 hours**.

We have a policy in place to avoid double booking appointments and to provide our patients with the best possible care. This policy helps us respect the time of our patients and focus solely on their dental needs during their appointment. It also ensures that we have availability for other patients seeking care. If you have any questions about this policy, please don't hesitate to contact us. We understand that emergencies and schedule changes can happen and will work with you to ensure that you receive the best possible care. We appreciate your cooperation in respecting our time and we'll always respect yours.

I confirm that I have read, understand, and agree to the terms of the Financial Policy as indicated by my signature below. A photocopy of this consent will be considered as valid as the original.

Signature of Patient or Responsible Party _____ Date _____

Relationship to the patient _____ Name if not the patient _____