Welcome

Thank you for selecting us.

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Patient Number ______________________

Name ______________________ Date ______________________

Soc. Sec. # ______________________ Birthdate ______________________

Address ______________________ City ______________________

State ______________________ Zip Code ______________________

Home Phone ____________ **Work Phone** ____________ **Cell Phone** ____________ **Email** ____________

Do you prefer to be contacted by phone, text or email? ______________________

Do you have a flexible work schedule? ____________ What is the best time of the day to reach you? ____________

If we have an opportunity to see you earlier for a scheduled appointment, would you like us to let you know? ____________

If Student, Name of School/College ______________________ Email ______________________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient's or Parent's Employer ______________________

Business Address ______________________ City ____________ State ____________ Zip Code ____________

Spouse or Parent's Name ____________ Employer ____________ Work Phone ____________

Whom May We Thank for Referring You? ______________________

Person to Contact in Case of Emergency ______________________ Phone ______________________

Patient Medical History

Physician ______________________ Office Phone ______________________ Date of Last Exam ______________________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain ______________________		
3. Have you had a CAT scan in the last year?	☐	☐
4. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? ______________________		
5. Have you ever taken Phen-Fen/Redux?	☐	☐
6. Do you use tobacco?	☐	☐
7. Do you use controlled substances?	☐	☐
8. Are you wearing contact lenses?	☐	☐

	Yes	No
9. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other ______________________		
10. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

Over Please

Patient Medical History (Cont.)

10. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐	Other ______________	☐	☐

Patient Dental History

Name of Previous Dentist and Location (optional) ______________________________ Date of Last Exam __________

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following	☐	☐
problems in your jaw?	☐	☐
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐

	Yes	No
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement ______________		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐
17. Would you be interested in tooth whitening/ cosmetic dentistry?	☐	☐
18. Have you ever had a bad experience with another Dentist or Physician?	☐	☐

19. Why did you leave your last Dentist? ______________

____

20. Please add anything else you feel is important. ______________

____

Julie L. Molin, D.M.D. ~ Family & Cosmetic Dentistry
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frontdesk@juliemolin.com

Responsible Party

Name of Person Responsible for this Account (if Other Than You):____

Address: ____ City/Zip: ___________________

Contact Number: ___________________________ Birth date: _______________ Soc. Sec. #:________________________

Employer: ____

Home Phone:__________________________ Cell Phone:______________________ Email___________________________

Currently a Patient in Our Office? Yes No

Name of Person Carrying Dental Insurance: ____

Birth date: ______________________ Soc. Sec. #: ____

Name of Employer: ___________________________ Union or Local #: _________________

Work Phone: ____________________ Relationship to Patient: Self Spouse Child Other: ______________________

Insurance Company: ___________________________________ Group #: ___________________

Policy/ID #: _________________ Ins. Co. Address: ____

Ins. Co. Phone Number: _______________________

Do You Have Any Additional Dental Insurance? Yes No If Yes, Complete the Following:

Name of Person Carrying Insurance: ____

Birth date: ______________________ Soc. Sec. #: ______________________

Name of Employer: ___________________________ Union or Local #: _________________

Work Phone: ____________________ Relationship to Patient: Self Spouse Child Other: ______________________

Insurance Company: ___________________________________ Group #: ___________________

Policy/ID #: _________________ Ins. Co. Address: ____

Ins. Co. Phone Number: _______________________

Dental Insurance Information

Our office participates with **Delta Dental Premier** and **CIGNA PPO** insurance only. If your insurance plan is NOT Delta Dental or CIGNA PPO, full payment is expected at time of service. At each appointment, please be prepared to bring with you; your dental insurance card, any updated medical information and method of payment. All other insurance plans other than CIGNA PPO and Delta Dental premier will be submitted as out of network. Please confirm that you have out of network benefits prior to your appointment .We will continue to electronically file claims, from ALL insurance companies, relating to the treatment performed in our office and address any denials or appeals when necessary. You will be responsible to notify the office with any claim concerns, denials or appeals.

Appointment reminders

If you would like reminders sent to you, please make sure we have your current information on file
Reminders will be sent on the day your appointment is made, 1 week before , 1 day before and on the day of your appointment. You must opt "in" to text notifications when text is sent to you.

Missed appointments

If you need to reschedule your appointment, we ask that you call the office at least 24 hours in advance. Any broken appointments with out 24 hour notice will result in a missed appointment fee of $65 per hour scheduled.

Authorization and Release.

I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information could be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and / or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Payment

Payment is expected at time of service. Payment options are :

1- Cash
2- Check
3- Care Credit
4- MasterCard, Visa, Discover and American Express

Any unpaid balances over 6 months old will be subject to collections and or small claims court, if written financial agreement has not been made. Small claims processing will result to an additional charge of $250 on your account.
Any unpaid balances over 60 days will be automatically charged a 14.99 % interest fee and will be turned over to our billing office and a $25.00 monthly fee will be charged.

Signature ____Date_____________________