EDGEVIEW DENTAL

New Patient Information

FIRST NAME	MIDDLE	LAST NAME	NICKNAME
SSN	DOB	HOME ADDRESS	ZIP CODE
HOME PHONE	WORK PHONE	CELL PHONE	SEX M☐ F☐
EMAIL	MARITAL STATUS		OCCUPATION
REF. DOCTOR	REF. PATIENT	STUDENT STATUS/ SCHOOL ATTENDING	

Primary Dental Insurance Coverage

SUBSCRIBER NAME	SSN	DOB
ADDRESS	RELATION TO PATIENT	
EMPLOYER	ADDRESS	
PLAN NAME	GROUP NUMBER	
INSURANCE COMPANY	ADDRESS	

Secondary Dental Insurance Coverage

SUBSCRIBER NAME	SSN	DOB
ADDRESS	RELATION TO PATIENT	
EMPLOYER	ADDRESS	
PLAN NAME	GROUP NUMBER	
INSURANCE COMPANY	ADDRESS	

Medical Insurance Coverage

SUBSCRIBER NAME	RELATION TO PATIENT
ADDRESS	PLAN NAME

FINANCIALLY RESPONSIBLE PARTY

NAME AND ADDRESS	
SIGNATURE	DATE

Emergency Contact Information

NAME	RELATION TO PATIENT	CONTACT PHONE

Which family member may we share dental information with?

NAME _____ RELATION TO PATIENT _____

AUTHORIZATION AND RELEASE

The information I've provided is accurate and complete to the best of my knowledge. I will not hold my dentist of any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

SIGNATURE _____ DATE _____

EDGEVIEW DENTAL

Medical History

PATIENT NAME	DOB	DATE CREATED

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body.

Please list primary doctor's name and phone number.	☐ YES	☐ NO	IF YES
Are you taking any medications, pills, or drugs? If Yes, please list.	☐ YES	☐ NO	IF YES
Do you use controlled substances? If Yes, please list.	☐ YES	☐ NO	IF YES
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? If Yes, for how long?	☐ YES	☐ NO	IF YES
Do you use tobacco (if yes, how much)?	☐ YES	☐ NO	IF YES
Do you have any anxiety, dental or otherwise? If Yes, please explain.	☐ YES	☐ NO	IF YES
What Pharmacy do you use? Name and location.	☐ YES	☐ NO	IF YES
Have you ever been diagnosed with Sleep Apnea? Have you had a sleep study done?	☐ YES	☐ NO	IF YES
Do you pre-medicate for dental appointments? If Yes, what for?	☐ YES	☐ NO	IF YES
Have you ever been hospitalized or had a major operation?	☐ YES	☐ NO	IF YES

Women: Are you... ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic	Other Allergies? Please List ☐ YES ☐ NO
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics	IF YES
☐ Gluten	☐ Ibuprofen			

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

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS or HIV positive	☐	☐	Circulatory Disorder	☐	☐	Fainting or Dizziness	☐	☐	Migraines	☐	☐
Alzhemiers or Dementia	☐	☐	COPD	☐	☐	Heart Attack or Failure	☐	☐	Mitral Valve Prolapse	☐	☐
Anemia	☐	☐	Clench or Grind Teeth	☐	☐	Hypoglycemia	☐	☐	Osteoporosis	☐	☐
Angina or Chest Pains	☐	☐	Cancer	☐	☐	Hemophilia	☐	☐	Psychiatric Care	☐	☐
Arthritis or Gout	☐	☐	Chemotherapy	☐	☐	High Blood Pressure	☐	☐	Pacemaker	☐	☐
Artificial Heart Valve	☐	☐	Cortisone Medicine	☐	☐	Hepatitis A, B, or C	☐	☐	Radiation Treatment	☐	☐
Asthma	☐	☐	Dry Mouth	☐	☐	Heart Murmur	☐	☐	Swelling of Limbs	☐	☐
Artificial Joint	☐	☐	Diabetes	☐	☐	Herpes/cold sores/blisters	☐	☐	Stomach or Intestinal Disease	☐	☐
Acid Reflux	☐	☐	Drug Addiction	☐	☐	High Cholesterol	☐	☐	Stroke	☐	☐
Auto Immune Disorder	☐	☐	Epilepsy or Seizures	☐	☐	Kidney Disease	☐	☐	Sleep Apnea	☐	☐
Blood Disorder	☐	☐	Excessive bleeding	☐	☐	Liver Disease	☐	☐	Tuberculosis	☐	☐
Bruise Easily	☐	☐	Easily winded or Shortness of Breath	☐	☐	Leukemia	☐	☐	Thyroid Disease	☐	☐
Congenital Heart Disorder	☐	☐	Emphysema	☐	☐	Low Blood Pressure	☐	☐	Ulcers	☐	☐

Comments:

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, Parent or Guardian _____ DATE _____

EDGEVIEW DENTAL

Office and Financial Policy

Thank you for choosing our office as your dental health care provider. We are committed to providing the highest quality care to all of our patients.

Payment is due at the time that service is provided. We accept all major credit cards, cash, checks, money orders, and Care Credit. Returned checks will be subject to an additional "Returned Check Fee" of $30.

As a courtesy to our patients with the benefit of dental insurance, we process all insurance claims electronically on your behalf. If your insurance company will reimburse our office directly, we ask that you pay your deductible and estimated copayment at the time services are provided. If your insurance company will only reimburse the subscriber directly, we ask that you pay in full at the time services are provided. Any insurance estimates provided by our office are strictly estimates only; all charges that are incurred are your responsibility regardless of your insurance coverage. If insurance payment is different than what was estimated, any remaining balance will be billed to you, and due upon receipt of that bill. If you are unable to pay a balance due on your account for any reason, we ask that you contact our office immediately so that appropriate arrangements can be made. If you have questions regarding an estimated balance due for proposed treatment, please contact the office at any time prior to scheduling your appointment, and we will be happy to assist you.

For any balance outstanding over 30 days, a $5 billing charge will be applied. If a balance extends to 60 days past due, a second billing charge is applied, and a 10-day collections notice is sent. At this time, if no payment is made and no arrangements have been put in place regarding the account, any scheduled appointments will be canceled, and the account will be reviewed for further collections measures.

Last-Minute Cancellation Policy: Our office requires 48 hours' notice for all appointment cancellations. A last-minute cancellation or failed appointment means that we are not able to offer that appointment to another patient who may be in need of treatment. Should you need to cancel your appointment without being able to give us 48 hours' notice, or you fail to attend your scheduled appointment, a "Broken Appointment Fee" of $50 may be assigned to your account. A secure answering machine is available for any cancellation messages that may need to be left outside of regular office hours.

I, the undersigned, have read and understand the above outlined Office and Financial policies. I understand that failure to comply with any of the above may result in my dismissal from the practice.

SIGNATURE of Patient, Parent or Guardian _____ DATE _____

PATIENT NAME _____ RELATIONSHIP _____

EDGEVIEW DENTAL

Acknowledgment of Receipt of Notice of Privacy Practices

I, _____, have received a copy of this office's Notice of Privacy Practices.

PATIENT NAME (Printed) _____

PATIENT SIGNATURE _____ DATE _____

Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining the acknowledgment
- ☐ Other (Please specify below)