Exceptional Dentistry of Siouxland
www.SmilesforSiouxland.com

Welcome

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us. We will be happy to help.

GETTING TO KNOW YOU

Name: _____ I prefer to be called: _____ ❑ Male ❑ Female

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated Birthdate: _____/ _____ / _____ S.S. #:_____

Home Address: _____ City: _____ State: _____ Zip:_____

Home Phone: (_____) _____ Work Phone: (_____)_____ Ext. _____ Pager: (_____) _____

Cell: (_____) _____ Email Address:_____

Employer: _____How long There? _____ Occupation:_____

Employers Address: _____City:_____ State: _____ Zip:_____

DENTAL INSURANCE INFORMATION

Insurance Co. Name: _____Phone: (_____) _____ Group Policy # _____

Insured's Name: _____ Insured's Birthdate: _____/_____/_____ Subscriber ID#: _____

Insured's Social Security #: _____ Insured's Employer: _____

PERSON RESPONSIBLE FOR ACCOUNT

❑ Same as above name: _____ Birthdate: _____/_____/_____ Relation: _____

Billing Address: _____City:_____ State:_____ Zip:_____

Home Phone: (_____) _____ Work: (____) _____ S.S.#: _____

Employer: _____ How long there? _____ Occupation:_ _____

1) Why did you select our office: _____

2. Whom may we thank for referring you? ❑ Phone book ❑ Newspaper ❑ Sign ❑ Website/Internet

❑ Patient _____ ❑ Other_____

3. Is another member of your family or relative a patient in our practice? _____

Person to contact in case of emergency: _____ Relationship to patient _____

Contact Phone Numbers: _____

PLEASE CHECK ONE:

When discussing my treatment plan, I prefer ❑ THE BIG PICTURE ❑ DETAIL BY DETAIL

When evaluating my smile, it's most important: ❑ WHAT I SEE ❑ WHAT OTHERS SEE

Please rate on a scale of 1-5 the importance of each of the following regarding your dental care (most important being #1)

___ PREVENTIVE DENTAL HEALTH CARE ___ FREEDOM FROM PAIN ___ EXCELLENCE & QUALITY OF SERVICE

___ COST & AFFORDABILITY ___ OTHER _____

Are you concerned about the following (Please check box): ❑ Whitening your teeth

❑ Replacing old mercury silver fillings ❑ Appearance of my smile ❑ Recurring or untreated gum disease ❑ Current pain

❑ Prevention of decay ❑ Mouth odor ❑ Other _____

I am interested in knowing about: (Please check box): ❑ Dentures ❑ Braces (Orthodontics) ❑ Cosmic Dentistry ❑ Implants

❑ Sleep Dentistry ❑ Improving my chewing function or smile

DENTAL HEALTH QUESTIONNAIRE

Please help us better understand your dental health needs and goals by answering the following questions. (check the best answer)

1. Have you had a full mouth set of X-rays (other that routine cavity detecting x-rays) within the last 3 years? ❑ Yes ❑ No

2. I have a ❑ low ❑ moderate ❑ high fear of going to the dentist.

3. My mouth and teeth are ❑ very ❑ moderately ❑ not (comfortable.)

4. I am very ❑ satisfied ❑ dissatisfied with the appearance of my teeth.

5. I think my present state of dental health is ❑ excellent ❑ good ❑ fair ❑ poor.

6. Please check which statement below best represents the level of dental health you wish to achieve
(some people begin at one level and progress to a higher level over time.)

HEALTH LEVEL I - Emergency Care ❑
I am only interested in emergency dental care for the relief of pan and/or cosmetic embarrassment. I am not very interested in thinking about the future of my teeth at this time.

HEALTH LEVEL II - Maintenance Care ❑
I am interested in maintenance care by taking an active part in the prevention of the disease process and the repair of existing problem. however, I'm not yet ready for a higher level of dental care due to limitations of time and/or money. I understand that maintenance care may not be enough to help me achieve maximum protection and longevity and that my dental health may not remain stable over time.

HEALTH LEVEL III - Comprehensive Care ❑
I am interested in comprehensive care to achieve and maintain a higher level of dental health. I am concerned about treating the causes of dental diseases, not simply the effects. I want all dental treatment provided to be the best available for maximum protection and longevity, so as to achieve long-term stable dental health.

HEALTH LEVEL IV - Comprehensive and Cosmetic Care ❑
I am interested in comprehensive and cosmetic care to achieve and maintain the highest level of dental health. I am concerned about treating the causes of dental diseases, not simply the effect. I want all dental treatment provided to be the best available in cosmetic dentistry for maximum protection, longevity, and esthetics, so as to achieve long-term stable, yet esthetic, dental health.

MEDIAL HISTORY INFORMATION

Name of Physician _____ Phone (_____) _____

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

❑ Allergies	❑ Diabetes	❑ Heart Surgery	❑ Rheumatic Fever
❑ Anemia	❑ Epilepsy or Seizures	❑ Hepatitis	❑ Rheumatism
❑ Angina	❑ Excessive Thirst	❑ High Blood Pressure	❑ Sickle Cell Disease
❑ Arthritis	❑ Fainting or Dizziness	❑ HIV*/AIDS	❑ Sinus Problems
❑ Artificial Joints*	❑ Fever Blisters/Cold Sores	❑ Kidney Problems	❑ Stroke
❑ Artificial Heart Valves*	❑ Frequent Cough	❑ Liver Problems	❑ Surgical Shunt*
❑ Asthma	❑ Glaucoma	❑ Metal Disorders	❑ Thyroid Problems
❑ Breathing Problems	❑ Heart Disorder (Congenital)*	❑ Mitral Valve Prolapse*	❑ Tuberculosis
❑ Cancer	❑ Heart Infection*	❑ Osteoporosis	❑ Ulcers
❑ Chemical Dependency	❑ Heart Murmur*	❑ Radiation Treatment	❑ Venereal Disease

Do you have any health problems not listed above or need further explanation? If yes, explain_____

Are you now under the care of a physician? If yes, explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? If yes, explain:_____

Are you taking and medications or herbals? If yes, list:_____

Are you allergic to any medications or substances? If yes, please check box below:

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Iodine ❑ Metal ❑ Latex ❑ Other _____

Have you used tobacco? If yes, explain: _____

Are you interested in quitting? ❑ Yes ❑ No

WOMEN (please check): ❑ Pregnant ❑ Trying to get pregnant ❑ Nursing ❑ Taking Oral Contraceptives
Are you using a contraceptive? ❑ Yes ❑ No
If yes, please read and initial. I understand that taking antibiotics my render contraceptives ineffective. _____

To the best of my knowledge all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment without fail.

_____ _____
Signature of patient or guardian Date

APPOINTMENTS POLICY

We value your time so you can expect us to see you at the appointed time and to keep you time spent in our office as short as possible. In return, when you make an appointment with us please be on time since we have reserved our time just for you. Please make every effort not to change your scheduled appointment. If you must change an appointment, please provide us at least **2 working days advanced notification** so that we may use our time to accommodate other patients. Broken and missed appointments create scheduling problems for other patients and our practice. We value your time, please value ours.

FINANCIAL POLICY

Unless another financial option is PRE-ARRANGED, payment in full is due the day of treatment, or on pre-op visits for sedation appointments should a patient have dental insurance with assignment to us, the estimated patient portion will be the amount due. Insurance payments without assignment will be sent to the insured with payment due in full.

Payment Options
1. For your convenience we accept Cash, Check, Visa, MasterCard, & Discover.
2. We also offer short and long-term financing options (interest free options may apply)

For Patients with Dental Insurance
Dental Insurance plans often pay less than the actual fee for service, therefore the patient or Guarantor is the responsible party for all dental services provided. Dental insurance in most cases is a benefit with limitations and should not be expected to take care of your costs. Your dental benefits and how they relate to your specific needs will be explained to you during the Treatment Discussion appointment.

Finance Charge and Fees
Balances in excess of 30 days are subject to a finance charge of 1.5% per month (18% annual).
Returned checks are subject to a $15.00 accounting fee.

NOTICE OF PRIVACY FOR PROTECTED HUMAN INFORMATION

I hereby acknowledge that I have received this practice's Notice of Privacy Practices and that I had the opportunity to review it. I understand that I may ask any questions I might have regarding this notice. _____ *Initial Here* (Signature of Parent or Guardian)

AUTHORIZATION AND CONSENT

General Consent to Treatment
I agree and consent to a dental examination by Dr's at www.smilesforsiouxland.com. I understand that additional diagnostic procedures and dental treatments my be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information
I authorize www.smilesforsiouxland.com to release any information regarding my dental/medical history, diagnosis or treatment to a third party and/or other health professionals.

Assignment of Insurance Benefits
I authorize and request my insurance company to pay my benefits directly to www.smilesforsiouxland.com

Photography Release
I authorize www.smilesforsiouxland.com to use photographs of me to help better understand my current dental condition and possible treatment options. I also authorize them to show these photographs for professional purposes.

I understand and will comply with office Appointment Policy. I understand and will comply with the office Financial Policy. I understand the Release of Information. I authorize Photographs taken of me to be show to other patients or potential patients.
_____ *Initial Here* (Signature of Parent or Guardian)

GENERAL FINANCIAL POLICY

If you have dental insurance, we want you to receive the full benefit of it. Our office staff will assist you in completing your insurance forms and verifying the coverage that your particular insurance plan provides. We accept assignment of your insurance payment, another service to you. You are responsible for any applicable deductible amounts and the portion that your insurance does not cover. Please be advised that although our office will make every effort to accurately estimate what your insurance will pay, this ***does not in any way***, guarantee actual payment from your insurance company. You will be financially responsible for the account, should your insurance plan(s) not honor financial benefits for any procedure(s).

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with rendering appropriate dental care and further authorize and consent to the doctor choosing and employing such assistance as he deems fit. I also understand that prior to treatment, a full explanation of the procedures(s) involved will be given by the doctor and/or his staff. I agree to pay for services rendered by this office. I also consent to the use of periodic appointment reminder phone calls and appointment reminder items sent via mail. I also understand that should my account become delinquent, my information may be released to a third party collection agency to assist with collection fees associated with treatment rendered in this office. I hereby attest that I have read the above section and understand it completely.

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_____
Signature of Patient/Guardian