EXQUISITE
DENTISTRY

We are pleased to welcome you to our practice. Please take a moment to fill out this form as completely as you can. If you have questions, we're happy to help.

Patient Name _____ D.O.B. _____

Phone Number _____ Email Address _____

Mailing Address _____

Emergency Contact Name _____ Phone Number _____

Primary Dental Insurance

Subscriber _____ D.O.B: _____

Insurance Carrier _____ ID#: _____

Secondary Dental Insurance

Subscriber _____ D.O.B: _____

Insurance Carrier _____ ID#: _____

Dental History

Reason for today's visit: _____ Are you in dental discomfort? _____

Former Dentist: _____ Phone Number: _____ Last Visit: _____

Check (✓) yes if you have had problems with any of the following:

☐ Bad Breath ☐Bleeding gums ☐Clicking or popping jaw ☐Food collection between teeth ☐Grinding or clenching teeth
☐Loose teeth or broken fillings ☐Periodontal treatment ☐Sensitivity to cold ☐Sensitivity to hot ☐Sensitivity to sweets
☐Sensitivity when biting ☐Sores or growths in mouth

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐Y ☐N

Other information about your dental health or previous treatment: _____

Medical History

Physician's Name _____ Phone _____

Last Visit: _____ Any serious illness or operations in the last 6 months? _____

Are you currently under physician care? If yes, please describe: _____

Have you ever had a blood transfusion? If yes, give approximate dates: _____

Have you ever used bone modifying medication? Brand names include Fosamax, Actonel, Didronel + Boniva. ☐Y ☐N

Women: Are you pregnant? ☐Y ☐ N Nursing? ☐Y ☐ N Taking birth control? ☐Y ☐ N

Do you have or have you had any of the following conditions:

- ☐ Y ☐ N AIDS/HIV
- ☐ Y ☐ N Alcohol/Drug Abuse
- ☐ Y ☐ N Anaphylaxis
- ☐ Y ☐ N Anemia
- ☐ Y ☐ N Anxiety
- ☐ Y ☐ N Arthritis/Rheumatoid
- ☐ Y ☐ N Artificial Heart Valve
- ☐ Y ☐ N Autoimmune Disease
- ☐ Y ☐ N Allergies
- ☐ Y ☐ N Asthma
- ☐ Y ☐ N Autism/Aspergers
- ☐ Y ☐ N Artificial Joint Replacement
- ☐ Y ☐ N Bleeding Problems
- ☐ Y ☐ N Heart Conditions
- ☐ Y ☐ N Circulatory Problems
- ☐ Y ☐ N Coronary Artery Disease
- ☐ Y ☐ N Cortisone Treatment
- ☐ Y ☐ N Depression
- ☐ Y ☐ N Diabetes
- ☐ Y ☐ N Eczema
- ☐ Y ☐ N Eating Disorder
- ☐ Y ☐ N Emphysema
- ☐ Y ☐ N Epilepsy
- ☐ Y ☐ N Fainting
- ☐ Y ☐ N Food Allergies
- ☐ Y ☐ N Genetic Disorder
- ☐ Y ☐ N Hepatitis A/B/C
- ☐ Y ☐ N Headaches
- ☐ Y ☐ N Kidney Disease
- ☐ Y ☐ N Liver Disease
- ☐ Y ☐ N Mitral Valve Prolapse
- ☐ Y ☐ N Osteoporosis
- ☐ Y ☐ N Pacemaker
- ☐ Y ☐ N Thyroid Disease
- ☐ Y ☐ N Psychiatric Care
- ☐ Y ☐ N Radiation Treatment
- ☐ Y ☐ N Respiratory Disease
- ☐ Y ☐ N Shingles
- ☐ Y ☐ N Shortness of Breath
- ☐ Y ☐ N Back Problems
- ☐ Y ☐ N Cancer _____
- ☐ Y ☐ N Chemotherapy
- ☐ Y ☐ N Blood Clots
- ☐ Y ☐ N Blood Disease
- ☐ Y ☐ N Heart Murmur
- ☐ Y ☐ N Substance Abuse
- ☐ Y ☐ N Surgical Implant
- ☐ Y ☐ N Tuberculosis
- ☐ Y ☐ N STI/STD
- ☐ Y ☐ N Hemophilia
- ☐ Y ☐ N Jaw pain
- ☐ Y ☐ N Herpes
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N Stent
- ☐ Y ☐ N Stroke

Medications + Allergies:

Please list any current medications:

_____

Please list any allergies to medications:

_____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there are any changes in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges, whether or not paid by insurance.

_____ _____

Patient Signature Today's Date

EXQUISITE
DENTISTRY

Appointment Policy

At Exquisite Dentistry, appointments are made in advance by reserving the appropriate time slots to accommodate you, the patient, and your treatment to be performed. Our staff spends time meticulously preparing for each appointment by sterilizing, organizing, and arranging the set up items prior to your arrival. This ensures that we achieve the high standard of care and treatment that we pride ourselves on. Therefore, we require at least 48 hours notice prior to canceling or rescheduling appointments.

Failure to do so will result in a non negotiable broken appointment fee of $75. If your appointment is for an hour or less, we will waive the first broken appointment. However, any appointments scheduled for an hour or more will not be waived. In the event of a second broken appointment, the patient will automatically receive a non negotiable broken appointment fee. We do understand that illness and emergencies arise. We ask you to notify our office as soon as possible if this occurs.

Prime time appointments are considered early mornings, late evenings, and Saturdays. Once an appointment has been broken during a prime time, we will no longer be able to schedule an appointment for you during that time. Arriving to an appointment more than 15 minutes late will result in the appointment being rescheduled and receiving a broken appointment fee.

Despite careful scheduling, emergencies can cause delays. We try our best to keep our schedule running on time. We do realize that your time is valuable. If your appointment is affected due to an unforeseen emergency, we'll try to notify you. Despite the situation you will receive the same quality dental care.

We thank you for your cooperation.

_____ _____

Patient Signature Today's Date

EXQUISITE
DENTISTRY

Financial Policy

Thank you for selecting us as your dental health providers. Our goal is to provide you and your family with optimal dental care. We want you to feel welcomed and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy.

Financial Agreement:

Patients are expected to pay for our services at the time they are rendered. Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service. At Exquisite Dentistry we understand that emergencies do arise and may affect timely payment of your account. If such extremes do occur, we ask that you please contact the office.

Insurance Information:

As a courtesy to our dental insured patients, we submit your claims to your insurance company free of charge. We will help you to receive your maximum allowable benefits. In order to achieve this goal, we ask our patients to be as informed about their dental plan as we are.

All of our doctors will diagnose treatment based on your dental health and not your insurance coverage. We ask that you please understand that dental insurance is not really insurance (a payment to cover the cost of a loss) at all. It is a money benefit, typically provided by an employer, to help their employees pay for routine dental services. Most dental plans are only designed to cover a portion of the total cost of a person's necessary dental treatment.

To help our patients plan accordingly for their restorative dental appointments, we will submit a pre-estimate to your dental insurance. Pre-estimates are not a guarantee of payment. Benefits are calculated based on current available benefits and payment eligibility. Estimates are subject to modification based on eligibility, coordination of benefits, the contract allowance, and the benefit plan in effect at the time services are completed.

If your dental insurance has not paid within 90 days of services rendered, you will need to make full payment to this office and you will be reimbursed when your insurance company makes a payment. After 90 days it will be the patient's responsibility to pursue payment from the insurance company. Your dental insurance is a contract between you and your insurance company. Therefore the insured has a better ability to deal with the insurance company and the employer responsible for the policy.

_____ _____

Patient Signature Today's Date

EXQUISITE
DENTISTRY

Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure(s), alternative treatment(s), or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

1. Treatment to be Provided

I understand that during my course of treatment the following care may be provided:

- Examinations
- Preventive Services (cleanings, radiographs and possibly fluoride)
- Local anesthetic
- Restorations and sealants
- Crowns, bridges, implants, complete dentures and partial dentures
- Periodontal treatment
- Endodontic treatment
- Extractions (with or without sutures)

→ Patient Initials _____

2. Drugs and Medications

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

→ Patient Initials _____

3. Changes in Treatment Plan

I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

→ Patient Initials _____

I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. I understand that ultimately I am responsible for any and all financial charges accrued on my account.

→ Patient Initials _____

_____ _____

Patient Signature Today's Date