Bethany Family Dental, P.C

Welcome to our practice!

Please help us by providing the following information.

Patient Information:

Name:_____ Date of Birth:_____

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

Cell Phone:_____ Home Phone:_____ Work Phone:_____

Email Address:_____ SS#_____ Drivers License_____

Spouse's Name:_____ Phone:_____

Emergency Contact:_____ Phone:_____

Who may we thank for referring you to our office?_____

In the event that we must contact you for scheduling changes, emergencies, etc., please indicate the best NUMBER to reach you during business hours:_____

Dental Insurance Information:

Primary Insurance Company:_____ Phone:_____

Name of Insured:_____ Relationship:_____

Date of Birth of Insured:_____ SS# of Insured:_____

Employer:_____ Phone:_____

ID#:_____ Group #:_____

Is there Secondary Insurance? Y N

Secondary Insurance Company:_____ Phone:_____

Name of Insured:_____ Relationship:_____

Date of Birth of Insured:_____ SS# of Insured:_____

Employer:_____ Phone:_____

ID#:_____ Group #:_____

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. This release is solely for the purpose of facilitating the billing and reimbursement, directly to Dr. Nathan Austria, DMD and Bethany Family Dental, P.C. of insurance benefits which I am entitled to. I hereby agree that I am financially responsible for all treatment rendered, and understand that complete payment will be made after each treatment, unless other financial arrangements have been previously made.

Patients Signature:_____ Date:_____

Bethany Family Dental, P.C.

Dental Health History Patient Name:_____

Name of your former dentist:_____ Date of last visit:_____

1. Is maintaining good oral health important to you? **Y** **N** If yes, why?_____

_____

2. On a scale of 1-10, 10 being best, where would you rate your smile? _____

3. On a scale of 1-10, 10 being best, where would you rate your oral health? _____

4. Have you experienced any of the following problems:

Bleeding Gums	**Y**	**N**	Sensitivity to hot or cold	**Y**	**N**
Bad breath or sour taste	**Y**	**N**	Snoring	**Y**	**N**
Burning sensations in mouth	**Y**	**N**	Food catching between teeth	**Y**	**N**
Soreness in jaw	**Y**	**N**	Grinding teeth	**Y**	**N**
Is it hard for you to open wide	**Y**	**N**	Pain/soreness around ears, eyes, face	**Y**	**N**
Clicking or popping in jaw	**Y**	**N**	Stiff neck muscles	**Y**	**N**
Do your parents wear dentures/partials	**Y**	**N**	Have your parents suffered from gum disease?	**Y**	**N**
Did you ever have braces	**Y**	**N**	Ever had a mouth or face injury	**Y**	**N**
Oral surgery of any kind	**Y**	**N**	Do you use any form of tobacco	**Y**	**N**

5. Does having dental treatment make you afraid or nervous? If so, what specifically bothers you? _____

_____

7. If you could change anything about your smile, which of the following would you want? (please circle)

Whiter	Close space or spaces	Replace chipped teeth
Replace missing teeth	Replace old crowns	Remove silver fillings
Remove stains/spots on teeth	Excess showing of teeth	Replace old plastic fillings
Straighter	Less gum showing	Reshape/resize teeth

8. Please answer this question: Where do you see your overall oral health and/or smile in the next 5 to 10 years?

_____

Which of the following are important to you in making your dental health decisions (please circle):

Convenience	Appearance	Relationship with dental team
Finances	Time	Quality of care
What insurance covers	Health	Detailed treatment explanations
Fear or anxiety	Comfort	Technology

Bethany Family Dental, P.C.

Medical History

It is very important to answer all questions truthfully and to the best of your knowledge so that we can best plan your dental care and avoid any unnecessary personal health risks. Please assist us by completing the following and let us know if you do not understand any part of this form:

Name:_____ Todays Date:_____

How would you describe your general health?
__Excellent __Good __Fair __Poor What do you consider to be your most important health issue?_____

_____

Birth date:_____ Age:_____ Height:_____ Weight:_____

Who is your personal physician?_____ Physician's telephone:_____

Have you ever had or been treated for any of the following diseases/conditions? Please check Yes or No and circle all that apply. Thank you.

YES NO **HEART**
Congestive Heart Failure
Congenital heart malformation
Valve problems/murmur
Chest pain/angina

YES NO **VASCULAR**
High/low blood pressure
Fainting/dizzy spells
Central venous catheter/PICC
Stoke/TIA

YES NO **BLEEDING DISORDERS**
Hemophilia
Anticoagulants
Bruise Easily
Low/High Platelets
Anemia
Transfusions
Sickle Cell Disease

YES NO **LUNGS**
Asthma, Bronchitis, Emphysema
Pulmonary fibrosis/scarring
Chronic Cough, short of breath
Pneumonia, tuberculosis

YES NO **LIVER**
Hepatitis (A, B, C, Autoimmune)
Jaundice
Cirrhosis, alcoholism

YES NO **DIGESTIVE TRACT**
Diet (special/restricted)
Ulcers/GI Bleeding
Gastric Reflux/Heartburn
Colitis, Crohns, IBS

YES NO **KIDNEY**
Dialysis
Acute or chronic Renal failure
Polycystic

YES NO **HORMONES**
Thyroid Problems
Diabetes/Pancreas Disease
Pituitary/Adrenal
Gender Hormone Issues

YES NO **MUSCLES/SKELETON**
Osteoporosis
Artificial joints (hip, knee, etc.)
Multiple Sclerosis
Myasthenia Gravis
Muscular Dystrophy
Trauma
Swollen ankles

YES NO **IMMUNOLOGIC**
Lupus
Other autoimmune disease
Immunosuppressive therapy
Use of prednisone or similar

YES NO **CANCER** (Type:_____)
Radiation Therapy
Chemotherapy
Surgery

YES NO **PSYCHIATRIC**
Psychiatric/Psychologic Care
Nervous/anxious
Depression
Developmental delay/autism
Behavior Issues
Learning Disability
Alzheimer's/Dementia

YES NO **NEUROLOGIC**
Seizures/Epilepsy
Parkinson's
Cerebral Palsy

YES NO **INFECTIOUS DISEASE**
HIV+
Sexually Transmitted Disease
Other Infectious Disease

YES NO **HEAD**
Sinus trouble/Hay fever
Migraine headaches
Cold sores/fever blisters
Vision/hearing impairment

YES NO **HABITS**
Tobacco (cigarettes, cigars, snuff)
Alcohol (social, heavy, alcoholism)
Drug use (street/prescription)

Please describe any conditions not listed, or use this space to give details about any of your medical issues:

_____

_____

_____

_____

Women: Some medications used in dentistry will cross the placental and breast milk carrier, and might affect the unborn fetus. Antibiotic use may reduce the effectiveness of birth control pills, and alternate methods are recommended if taking them.

Are you pregnant? **Y**, _____months **N** Possibly or Not sure Do you use birth control pills or injection? **Y N**

Are you breastfeeding? **Y N** Menopause? **Y N** Using hormone replacement therapy (HRT)? **Y N**

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Medical History (Page 2)

Please list all medications you are currently taking. Be sure to include over-the-counter and herbal products as well as any prescriptions you are currently taking: (attach extra paper if necessary)

Name of medication:	Dose/How often:	Reason for taking:

Please list all operations you have had:

Please list any allergies and/or bad reactions you have had: **____CHECK HERE IF NO KNOWN ALLERGIES**

To What:	What Happens:	How severe:

Would you care to speak to the dentist privately about any health issues? ___Y ___N

I have read and understand the questions on the health history. I have answered them to the best of my knowledge.

Signature of Patient_____ Date:_____

Signature of Legal Guardian, if applicable_____ Date:_____

Legal Guardian's relationship to patient:_____

Doctor's Use:

Bethany Family Dental, P.C.

Financial and Cancellation Policy

Bethany Family Dental, P.C. depends upon reimbursement from the patient for costs incurred in their care. As a condition of treatment by this office, the patient must make all financial arrangements in advance. All emergency dental services must be paid for at time of service. Accepted methods of payment are: cash, check, and all major credit cards including Discover, American Express, Visa and Mastercard.

Patients with Insurance: Insurance is billed as a courtesy to our patients. Insurance can be difficult to calculate due to many factors including: waiting periods, deductibles, excluded services, and annual maximums. We do our best to advise patient, however, the contract is between the patient and the insurance company. **The patient is fully responsible for all charges for dental services and agrees to pay any balance not paid by their insurance company regardless of what estimate was quoted them.** If the patient balance is unpaid for a time greater than 90 days, the patient will be assessed interest in the amount of 21% annually.

Cleaning appointments: Bethany Family Dental, P.C. will bill the patients' insurance for all cleaning appointments and the patient will be mailed a bill for any portion due. We will collect on date of service except only in extenuating circumstances, which will be discussed before the appointment.

Treatment appointments: Bethany Family Dental, P.C. will provide an estimate of your patient portion and will gladly send in a pre-determination to get a more accurate estimate. This is not a guarantee of benefits. The patient will be responsible for the estimated portion **ON DATE OF SERVICE.** If the **estimated patient portion is less than the amount that insurance actually covers, that is also considered patient portion.** If insurance pays more than the estimated amount we will be happy to refund the patient the difference.

Cancellations: Our office requires that you give a minimum of one working day advanced notice for any cancellation or rescheduling of an appointment. Late cancellations or failure to keep an appointment will result in a **$50 fee per patient, per hour reserved.** We are sensitive to the fact that emergencies do come up but ask that the patient do their best to keep us informed.

Warranty: Bethany Family Dental, P.C. has a sincere desire to aid our patients in the event of a crown/veneer breaking or an implant failure. If the work was done at our office within the last 5 years and the patient has come in for routine exams and check ups (**every 6 months as recommended by ADA**) they will qualify for free replacement depending on circumstances. All cases must first be reviewed by Dr. Austria before making the final decision of warranty coverage. If the patient has not been seen within the last 6 months, the incident will be reviewed by Dr. Austria.

I have read and agree to the above policies.

Responsible Party Signature_____ Date:_____

Responsible Party Printed Name_____ Date:_____