Welcome
Please Tell Us About Yourself

Name: ____
Last First MI Title

Preferred Name: ______________________________ ☐ Male ☐ Female

Address: ____

City ______________________ State ________ Zip ____________

SSN: ______________________ DOB: ______________________

Home Phone: ______________________ Work Phone: ______________________

Cell Phone: ______________________ E-mail Address: ______________________

Employer: ______________________ Occupation: ______________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

How did you hear about our office? ______________________________________

Do you prefer to be contacted for appointment confirmation via e-mail or phone? (please circle preference)

Dental Insurance-Primary

Subscriber Name: ______________________ Relationship to Patient: ______________________

Subscriber SSN/ID: ______________________ Subscriber DOB: ______________________

Subscriber Employer: ____

Insurance Company Name: ____

Insurance Company Address: ____

Insurance Company Phone: ________________ Group Number: ______________________

Dental Insurance-Secondary

Subscriber Name: ______________________ Relationship to Patient: ______________________

Subscriber SSN/ID: ______________________ Subscriber DOB: ______________________

Subscriber Employer: ____

Insurance Company Name: ____

Insurance Company Address: ____

Insurance Company Phone: ________________ Group Number: ______________________

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Rauch Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: ____

Relationship: ______________________ Date: ______________________

Dental History

Patient Name______________________________ Date__________________

How may we help you today?____

Your current dental health is: Good Fair Poor

Do you have chipped teeth? Yes No

Do you have straight teeth? Yes No

Are your teeth sensitive to hot, cold or anything else? Yes No

Are you currently in pain? Yes No

Do you like your smile? Yes No

Are you happy with the color of your teeth? Yes No

Have you lost any teeth? Yes No

Do you require antibiotics before dental treatment? Yes No

Have you ever had gum treatment? Yes No

Do you now or have you had any pain/discomfort in you jaw? (TMJ) Yes No

Do your gums bleed? Yes No

How many times do you: floss/week?_____________ brush/day?____________

Have you ever had a serious/difficult problem with any previous dental work? Yes No

When was your last cleaning?____

When was your last dental visit?____

Why did you leave your previous dentist?____

How did you hear about us?

Mailer__ Newspaper__ Website___ Referral___ Who referred you?_________________________

We offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Sapphire Tooth Whitening	Veneers/Lumineers	Bonding
Smile Makeover	Sealants	Night/Sports Guards
Crown and Bridge	Partials/Dentures	

Financial Policy

We believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

Initial

_____•We require payment in full for your portion at the time of service. We accept MasterCard, Visa, Discover, American Express, cash, and checks (for existing patients with established payment history). **We do not accept checks for over $500.00 for any patient.** If you are in need of an extended finance option, we also work with CareCredit, who offers 6 or 12 month "same as cash" or longer terms with interest bearing revolving charge designed to meet your treatment plan needs on approved credit.

_____•A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at **least 24 hours notice.**

_____•In the event of an emergency after regular business hours a **$55.00 emergency fee** will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged **$125.00 after hours emergency fee**.

Insurance Policy

_____•Your dental benefits are based upon a contract made between your employer and an insurance company. **If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you**.

_____•We currently accept many private care insurance plans (plans that do not require you to select a dentist form a list or require our office to accept a reduced fee for service) This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change: therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you the exact out of pocket figures you may require.

_____•We will bill your insurance as a courtesy. If insurance does not pay within 90 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

I agree with the above conditions.

Print Name:____

Patient/Parent Signature:____

Medical History

Are you under the care of a physician? ☐ Yes ☐ No
Please explain: ______________________________
Physician's Name: ________________ Phone number____________ Date of last visit________
Your current health is ☐ Good ☐ Fair ☐ Poor
Do you use tobacco in ANY form? ☐ Yes ☐ No
Have you had any metal rods, pins or implants placed? ☐ Yes ☐ No
Are you taking any medications? ☐ Yes ☐ No
Please list each one: ______________________________
____

Yes	No	Conditions
__	__	Abnormal Bleeding/Hemophilia
__	__	Sinus Problems
__	__	Stroke Date_____
__	__	Thyroid Problems
__	__	Ulcers
__	__	Artificial Heart Valve
__	__	Rheumatic Fever
__	__	Kidney Problems
__	__	Diabetes
__	__	Liver Disease
__	__	Hepatitis Type__
__	__	Asthma/Difficulty Breathing
__	__	Emphysema
__	__	Psychiatric Problems
__	__	Epilepsy/Seizures Last___
__	__	Facial Surgery
__	__	Fainting Spells
__	__	Sexually Transmitted Disease
__	__	HIV/AIDS

Yes	No	Conditions
__	__	Glaucoma
__	__	Allergies
__	__	Anemia
__	__	Angina
__	__	Arthritis
__	__	Drug Abuse
__	__	High Blood Pressure
__	__	Low Blood Pressure
__	__	Fever Blisters
__	__	Joint replacement/Implant
__	__	Congenital Heart Defect
__	__	Heart Murmur/Prolapse
__	__	Pacemaker
__	__	Radiation Therapy Date___
__	__	Chemotherapy Date___
__	__	Cancer Type___
__	__	Heart Attack Date___
__	__	Heart Surgery Date___
__	__	Frequent Headaches

Yes	No	Allergies
__	__	Penicillin
__	__	Antibiotics _____
__	__	Latex
__	__	Sulfa
__	__	Sulfa drugs
__	__	Tetracycline
__	__	Other __________

Yes	No	If female, Please Answer
__	__	Are you taking Birth Control
__	__	Are you Pregnant? # of weeks___
__	__	Are you Nursing?

Nearest relative not living with you:
Name:__________________________ Relationship: ________________
Address: ______________________________ Phone: __________________

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: ______________________________ Date: ____________________