Thank you for selecting our dental team. We will always offer you the most current dental care available. To help us to better serve you, please fill out these forms for us. Thank you for your cooperation.

The Smiles By Arnold & Associates Team

Today's Date _____

Personal Information

Name _____

Social Sec. # _____ Date of Birth _____

Preferred First Name: _____ ☐ Minor ☐ Single ☐ Married

Address _____ City, State, Zip _____

Your Employer _____ Your Occupation _____

Spouse's Name _____

Spouse's Employer _____ Spouse's Occupation _____

How did you find out about our office? _____

How May We Contact You?

Home Phone # _____ Work Phone # _____

Cellular Phone # _____ E-Mail _____

Pager # _____ Fax # _____

Where do you prefer to receive calls? ☐ Home ☐ Work ☐ Cell

When is the best time to reach you? Time _____ Day _____

Responsible Party

Name _____ Relation to patient _____

Date of Birth _____ Social Sec. #_____ Driver's License # _____

Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information

Do you have a dental benefit plan? ☐ Yes ☐ No

If yes, what carrier?_____ Insurance Phone # _____

If yes, name of insured: _____

Social Sec. # _____ Date of Birth _____

Do you have secondary coverage? ☐ Yes ☐ No

If yes, what carrier? _____ Insurance Phone # _____

Medical Health

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Date of Last Physical: _____
Name & Address of Physician: _____
Please list all medications you are presently taking: _____
_____
Have you been hospitalized or under a doctor's care during the past 3 years? ☐ Yes ☐ No
Has a doctor told you that you need antibiotics to pre-medicate for dental work? ☐ Yes ☐ No

Please check all of the following you have had or now have:

❍ AIDS/HIV	❍ Drug/Alcohol Abuse	❍ Kidney Disease
❍ Anemia	❍ Emphysema	❍ Liver Disease
❍ Arthritis	❍ Epilepsy/Seizures	❍ Lupus
❍ Artificial Joints	❍ Fainting	❍ Mental Disorders
❍ Asthma	❍ Fibromyalgia	❍ Osteoporosis
❍ Blood Diseases	❍ GERD	❍ Pacemaker
❍ Blood Transfusions	❍ Heart Disease	❍ Radiation Treatment
❍ Cancer/Chemotherapy	❍ Heart Murmur	❍ Rheumatoid Arthritis
❍ Cold Sores	❍ Hepatitis- A B C Other	❍ Stroke
❍ Congential Heart Defect	❍ High/Low Blood Pressure	❍ Ulcer
❍ Diabetes	❍ HPV	❍ Venereal Diseases

Do you have any disease, condition or problem not listed? _____
Are you allergic to: ☐ Penicillin ☐ Codeine ☐ Local Anesthetic (injected) ☐ Other _____
Are you subject to prolonged bleeding? ☐ Yes ☐ No
WOMEN: Are you pregnant? ☐ Yes ☐ No Are you taking birth control medication? ☐ Yes ☐ No

Finance

Payment of portions not covered by insurance is expected at each appointment. For your convenience, we offer the following methods of payment. Please check the option that you prefer. If you have any questions concerning financial arrangements, it will be our pleasure to assist you.
☐ Cash ☐ Personal Check ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express
Credit Card #: _____ Exp. Date: _____ Security Code: _____

Authorization, Release & Agreement to Pay for Services Rendered

I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care, to third party payers and/or health practitioners. I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

I understand that payment is due at the time of service. I understand that if my account reaches collection status (90 days), my account may be turned over to a collection agency. I will pay ALL costs of collection, including court costs and attorney's fees incurred for collection. Additionally, if my account reaches collection status (90 days), I agree to pay a monthly late fee in an amount equal to 1.5% of my remaining balance.

I, _____, verify all information provided on these forms is completely accurate to the best of my knowledge.

Signature of patient (or parent if minor) _____ Date _____

Dental History

1. Are your teeth sensitive to:
   Heat? ☐ Yes ☐ No
   Cold? ☐ Yes ☐ No
   Sweets? ☐ Yes ☐ No
   Biting Pressure? ☐ Yes ☐ No
   If yes, which areas? _____
_____

2. Are you dissatisfied with the way your teeth look?
   Color? ☐ Yes ☐ No
   Shape? ☐ Yes ☐ No
   Spaces? ☐ Yes ☐ No
   Other? _____
   If yes, what would you like to change? _____
_____

3. Are you missing any teeth? ☐ Yes ☐ No
   If yes, how long have these teeth been missing? _____

4. Do your gums bleed when:
   Brushing? ☐ Yes ☐ No
   Flossing? ☐ Yes ☐ No

5. Do you smoke? ☐ Yes ☐ No
   If yes, how long and how much?
_____

6. Do you drink pop? ☐ Yes ☐ No
   If yes, how much per day? _____
_____

7. How often do you:
   Brush your teeth? _____
   Floss your teeth? _____

8. Has the fear of dental work kept you from regular dental visits? ☐ Yes ☐ No
   If yes, are you interested in sedation dentistry? ☐ Yes ☐ No

9. Are you deeply concerned about the finances required to return your mouth to excellent dental health? ☐ Yes ☐ No

10. When was your last dental appointment and what did you have done? _____
_____
_____

11. How long since your last thorough examination with full mouth x-rays? _____

12. Who was your previous dentist?
_____

13. What prompted you to seek dental care at this time? _____
_____
_____

14. Is there anything else that we should know? _____
_____
_____
_____
_____
_____
_____
_____

How Can We Make Your Appointment More Comfortable?

Would you like:

- ❍ Fresh coffee when you arrive?
- ❍ A personal CD player to listen to during your treatment?
- ❍ A blanket to help keep you warm?
- ❍ A paraffin wax treatment for your hands?
- ❍ Sunglasses to wear during your appointment?
- ❍ A pillow to help support your neck?
- ❍ To use a chair massage pad?

Anything that we have not thought of? _____

What Did You Not Like About Your Past Dental Appointments?

- ❍ Was the treatment uncomfortable?
- ❍ Was the staff unfriendly?
- ❍ Were the fees not explained before your appointments?

Anything that we have not thought of? _____

What Is The First Thing You Would Like Us To Help You With?

Please list in order of importance:

_____
_____
_____
_____
_____

Photographic Release

Dr. Arnold and his team often take digital photos in order to properly document the condition of your teeth and gums. Additionally, these photos will help us to make more accurate diagnoses and may be used to better explain your existing dental health. Dr. Arnold may publish articles and make presentations to other dentists where these photos are invaluable in explaining the latest techniques and the results that can be achieved when done precisely. My signature acknowledges that photographs of me may be used for educational purposes as stated above.

Signature of Patient _____ Date _____

Sleep Questionnaire

1. Do you experience frequent, heavy snoring? ☐ Yes ☐ No
2. Do you notice significant day time drowsiness? ☐ Yes ☐ No
3. Have you been told you stop breathing while sleeping? ☐ Yes ☐ No
4. Are you aware of any teeth grinding at night? ☐ Yes ☐ No
5. Do you have morning headaches? ☐ Yes ☐ No
6. Do you wear a CPAP? ☐ Yes ☐ No
   If yes, when did you start wearing it? _____
   If yes, who prescribed it? _____
7. Do any other members of your family wear a CPAP? ☐ Yes ☐ No

Please take the following "Epworth Sleepiness Test".

How likely are you to fall asleep in the following situations?

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Activity	**Score**
Sitting and reading	_____
Watching television	_____
Sitting, inactive, in a public place (theater, meeting)	_____
As a passenger in a car for an hour with no break	_____
Lying down to rest in the afternoon, if circumstances permit	_____
Sitting talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car while stopped for a few minutes in traffic	_____
Total Score:	_____

A score of ten or above indicates you may be having a problem with daytime sleepiness.

Smiles By Arnold & Associates

OUR FINANCIAL ALLIANCE

Our goal in discussing financial arrangements with you is straightforward:

To create an understanding and partnership in the settlement of your account.

It is important to us that the quality of our business services matches the quality of our dentistry. We want the handling of your account, from the start through the final payments to be perceived as an extension of the dental care we provide you and your family.

PATIENT'S ROLE

As with any partnership, both parties have a role to play. Our role is to provide you with quality service. In turn, your role is to pay for your treatment in a timely manner. Our team will work with you to determine financial arrangements that make sense for both of us. With an agreement made, our joint follow-through will result in a win for everyone.

In developing a financial arrangement it is important to remember your dental future. Our experience has shown that when an account lingers, patients are likely to defer their appointments. It is discouraging to add new charges to an account when trying to pay off old charges. With this in mind, we will concentrate our efforts on clearing your account in as short a time as is comfortable for both of us.

All patients must complete our Financial Alliance Form before seeing the doctor.

PAYMENT OPTIONS

1. A 5% bookkeeping adjustment will be made when you pre-pay for services over $500.

2. Full payment is due at the time of service with cash, check, Visa, MasterCard, Discover or American Express.

3. We offer access to extended payment plans with credit approval.

4. If you have dental insurance, we will estimate what your insurance company will pay. We require payment of your uninsured portion upon receipt of services.

REGARDING INSURANCE

Each insurance company is different, so please note that your initial payment at our office for the above noted procedures is only an estimate. Your insurance policy is a contract

between you and your insurance company. We are not a party to that contract. However, as part of the financial arrangement process, we will bill your insurance company for your procedures and help you to maximize your reimbursement. Any unpaid balance after insurance pays is due within 14 days. In the event that your insurance company denies payment of a service, you are responsible for that fee. If your insurance company has not paid on your claim within 45 days, the full balance will automatically be transferred to you. After 45 days, any balance remaining on your account may be charged to your credit card.

Type of credit card _____
Name on the credit card _____
Credit card # _____ Exp. Date _____ Security code _____

MISSED APPOINTMENTS

We reserve the right to charge for missed appointments at the rate of a normal office visit. Please help us serve you and our other patients better by keeping scheduled appointments. Appointments that are missed or changed at the last minute are then unavailable to patients who need appointments. Please consider your schedule carefully when making appointments.

I understand that payment is due at the time of service. I understand that if my account reaches collection status (90 days), my account may be turned over to a collection agency. I will pay ALL costs of collections, including court costs and attorney's fees incurred for collection. Additionally, if my account reaches collection status (90 days), I agree to pay a monthly late fee in an amount equal to 1.5% of my remaining balance.

I have read the Financial Alliance. I understand and agree to abide by the policies therein.

Patient Signature: _____ Date: _____

Financial Coordinator: _____ Date: _____