Patient Information

Please take a few minutes to fill out this form as completely as you can.
If you have questions we'll be glad to help you.
We look forward to working with you in maintaining your dental health.

Tell Us About You

Name: _____

I prefer to be called: _____ ❒ Male ❒ Female

Birthdate: ___/___/___ Age: _____ SS #: _____

Home Address: _____

City _____ State: _____ Zip: _____

❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated
❒ Domestic Partner

Preferred #

Home #: _____ ❒

Wk #: _____ ❒

Cell #: _____ ❒

Employer: _____

How long there? _____ Occupation: _____

Who may we thank for referring you? _____

Other family members seen by us: _____

_____

Previous/Present Dentist: _____

Last visit date: _____

To better serve you, may we contact you via email or text messaging? _____

E-mail address: _____

Spouse Information

Their Name: _____

Employer: _____

Wk #: _____ Ext.: _____ Cell # _____

Birthdate: ___/___/___ SS #: _____

Emergency Information

In the event of an emergency, who should we contact?

Name: _____

Relationship: _____

Wk #: _____ HM #: _____

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group #: _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthday: ___/___/___

Subscriber ID: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group #: _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthday: ___/___/___

Subscriber ID #: _____

Insured's Employer: _____

Medical Insurance Information

Name: _____

Insurance Co. Name: _____

Pol. #: _____ Gr. #: _____

Subscriber: _____

Allergy Information

Y N Penicillin
Y N Aspirin
Y N Erythromycin
Y N Other _____

Y N Dental Anesthetics
Y N Tetracycline
Y N Codeine

Please list any other drug that you are allergic to: _____

_____

Are you allergic to latex? ❒ Yes ❒ No

Do you have food allergies? ❒ Yes ❒ No If so, to what? _____

_____

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: _____ Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

Are you taking any prescription/over-the-counter drugs?

☐ Yes ☐ No If yes, please list each one: _____

_____

Are you taking any weight loss medication (Phentermine, Redox)? ☐ Yes ☐ No

Are you taking any herbal supplements? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems? Please circle either Y or N for <u>each</u> item.

Y N	Acid Reflux	Y N	Hemophilia/abnl bleeding
Y N	Anemia/radiation treatment	Y N	Hepatitis
Y N	Anxiety / Depression	Y N	High/low blood pressure
Y N	Arthritis	Y N	HIV+/AIDS
Y N	Artificial bones/joints	Y N	Hormone Disorder
Y N	Artificial valves	Y N	Hospitalized for any reason
Y N	Asthma	Y N	Hypertension
Y N	Blood transfusions	Y N	Irregular Heartbeat
Y N	Cancer/chemotherapy	Y N	Kidney problems
Y N	Congenital heart defect	Y N	Mitral valve prolapse
Y N	Diabetes	Y N	Psychiatric problems
Y N	Difficulty breathing	Y N	Rheumatic fever
Y N	Drug/alcohol abuse	Y N	Severe/frequent headaches
Y N	Emphysema/glaucoma	Y N	Shingles
Y N	Epilepsy/seizures	Y N	Sinus problems
Y N	Erectile Dysfunction	Y N	Thyroid Disease
Y N	Fever blisters	Y N	Tuberculosis (TB)
Y N	Heart attack/stroke	Y N	Ulcers/colitis
Y N	Heart murmur	Y N	Venereal disease
Y N	Heart surgery/pacemaker	Y N	Weight Gain

Please discuss any serious medical problems that you have ever had: _____

FOR WOMEN ONLY:

Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Dental History

Why have you come to the dentist today? _____

_____

Are you a smoker? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

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

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Dry mouth/swallowing? ☐ Yes ☐ No

How many times a day do you brush? _____ Floss? _____

Type of bristles: ☐ Hard ☐ Medium ☐ Soft

Questionnaire

Do you feel tired or easily fatigued during day? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No

Do you wake up with a dry mouth or sore throat? ☐ Yes ☐ No

Do you feel you have restless or fitful sleep? ☐ Yes ☐ No

Do you experience choking, snorting or gasping during sleep? ☐ Yes ☐ No

Do you awaken in the morning still feeling tired or groggy? ☐ Yes ☐ No

Do you have occasional feelings of "confusion" or "spaced out"? ☐ Yes ☐ No

Do you suffer from low sex drive? ☐ Yes ☐ No

Do you get up frequently during the night? ☐ Yes ☐ No

Do you experience forgetfulness and difficulty concentrating? ☐ Yes ☐ No

Do you get Headaches / Migraines? AM____ PM____

How many headaches (H) and migraines (M) each week? ____(H) / ____(M)

Each month? ____(H) / ____(M)

Do you clench your teeth at night or during day? ☐ Yes ☐ No

When you wake up, does your jaw joint or muscles feel tight or sore? ☐ Yes ☐ No

Are you aware of any of the following? ☐ Yes ☐ No

Popping/clicking, Grinding or Noise in the jaw joints

Have you noticed a change in your bite? ☐ Yes ☐ No

Do you fall asleep sitting, reading, watching TV or driving? ☐ Yes ☐ No

Have you been in a motor vehicle accident in the past year? ☐ Yes ☐ No

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment. I have received Dr. Cavendish's notice of privacy practices.

Signature: _____ **Date** _____

FINANCIAL POLICIES

FOR DR. MATTHEW CAVENDISH

1. **Cancellation Policy:** We reserve the right to charge the value of the appointment as a fee for missed appointments that are not cancelled at least **48 business hours** in advance.
2. **Payments:** The patient portion for all services performed must be paid in full at the time of treatment, unless prior arrangements have been approved.
3. **Insurance:** All services performed are charged directly to the patient and you are personally responsible for payment of all services. Our office will assist in preparing and submitting insurance claims and reasonably assist in making collections from insurance companies. We will credit any such insurance payments to your account. However, all estimated insurance payments are **ESTIMATES** only. **We do not guarantee any payments by an insurance company** for services rendered by Dr. Cavendish. Any and all amounts not paid by the insurance company for services are your responsibility.
4. **Benefits:** Our office verifies benefits as a courtesy to our patients. A disclaimer is read to us by the insurance company when we verify benefits stating that the benefits verified are not a guarantee of payment, claims will be reviewed for medical necessity and payments will be made based off the individual's plan. Based on potential insurance misinformation, your out of pocket cost could be more than our estimate. We recommend you verify your own policy if this is a concern.
5. **Pre Authorization or Pre Determination:** Our office will do a pre authorization if it is required through your insurance, if a pre authorization or determination is denied, it will be the patient's responsibility to appeal with their own insurance.
6. **Claim Appeals:** Our office will do one complimentary appeal per claim that is denied. If the initial appeal is denied it will be the patient's responsibility to pay for any unpaid service or balance. Any second level appeals will be the responsibility of the patient.

I have completed the form and have read the above financial and insurance policies and agree to the same.

_____ _____

Patient, Parent or Guardian's Signature **Date**

_____

Relationship to Patient