IVY DENTAL

New Patient Form:

Welcome to Ivy Dental! We are very glad to have you in our office and would like to learn a little more about you. These questions will help guide us in providing you with the best possible care. Thank you for taking a minute to fill these questions out thoroughly so that we can keep you safe and work to give you the smile you desire.

Name: _____ Date of Birth: _____

Address: _____ Apt. # _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Social Security Number: _____

Employer: _____ Occupation: _____

Work Address: _____ Work Phone: _____

Marital Status: _____ Spouse's Name: _____

Spouse's Employer: _____ Occupation: _____

Work Address: _____ Work Phone: _____

Do you have children? If so please list names and ages:

_____

How did you hear about us?

Patient:_____

Doctor:_____

Webpage _____ Magazine _____ Sign _____ Bike Team _____ Facebook_____

Other_____

Do you have a dental benefit plan? _____ If yes, carrier _____

Policy Holder's Name: _____ Policy Holder date of birth: _____

Policy Holder SSN:_____ Policy Holder Employer: _____

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DENTAL HISTORY

Please answer Yes No

1. Are your teeth sensitive to: Heat? Cold? Sweets? Biting Pressure?

2. Does food constantly get stuck between certain teeth in your mouth?

3. Are you dissatisfied with your teeth in any way?

For example: color, shape, spaces, etc.

4. Do your gums bleed when brushing?

5. Do you have an unpleasant taste or odor in your mouth?

6. Do you smoke or use smokeless tobacco products?

7. How often do you brush your teeth? _____ Floss? _____

8. Has the fear of discomfort kept you from regular dental visits?

9. Are you interested in hearing about financial options we offer to help to make returning your mouth to better health more possible?

10. When was your last dental appointment? _____

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

_____

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

_____

13. Why did you leave your last dentist? _____

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MEDICAL HISTORY

1. Do you have any general health problems?

If so, please specify: _____

2. Are you currently under a physician's care? YES NO

Reason: _____

3. Please list any previous surgeries with dates of procedure:

_____

_____

Name, phone # and Address of Physician:

_____

3. Are you currently taking any drugs or medication?

If so, please specify: _____

_____

_____

4. Are you currently pregnant? _____ If yes, due date? _____

5. To the best of your knowledge, are you or have you ever been afflicted with any of the following…

Heart Ailment _____ Respiratory Disease _____ Diabetes _____

Hepatitis _____ Rheumatic Fever_____ Prolonged Bleeding _____

Epilepsy _____ Healing Complication_____ High Blood Pressure____

What BP is typical for you? _____

Allergy to any Drugs? Yes_____ No_____

If so, what? _____

Is there any additional information you would like for us to know? _____

_____

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Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance.

All co-payments are due at the time services are rendered.

Any emergency and/or after hours dental services are subject to additional fees.

Patients who carry dental insurance understand that payment for all services furnished are ultimately their responsibility. This office cannot render services on the assumption that our charges will be paid by an insurance company. As a courtesy to our patients, we will prepare and submit dental claims and assist in making collections from insurance companies. Any such collections will be credited to the patient's account.

In this office we believe in providing our patients with the utmost in care. This means using the best materials available in order to promote and preserve a healthy smile. We have taken great care to use Eco Friendly practices which in some instances increases fees and the insurance carriers may try to downgrade. We are an amalgam free practice and use BPA free filling materials. If the insurance carrier downgrades your filling to a silver amalgam patient agrees to be responsible for the difference in price.

X-rays and Photographs:

I authorize Dr. Harding and her team to take any x-rays and photographs deemed necessary for the detection and diagnosis of oral diseases. I authorize the release of this and any other information to my insurance company necessary for processing my dental claim (if applicable and according to HIPPA regulations).

I authorize Dr. Harding and staff to use my photograph for marketing: Yes _____ No _____

Appointment Policy:

If you find it impossible to keep an appointment, for consideration of other patients' needs, we ask for 48 hours' notice. Appointments cancelled or missed without 24 hours' notice are subject to a missed appointment fee.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay for services at the time they are rendered or within 7 business days of billing if credit is extended. Outstanding balances may be subject to additional charges. I further agree to pay all costs and reasonable attorney fees if my account has to be turned over to a third party collection agency.

I have read and agree to the above terms of treatment.

X _____ Date: _____

Relationship to Patient: _____

(Signature of Patient or Responsible Party) X _____

What is the best way we can contact you? Please check all that apply and note preferred method.

Phone _____ Text Message _____ Email _____