PATIENT INFORMATION:

Date ______________

Patient's Name ____________________________________ Age _____ Date of Birth __________________

Address ____ Home phone ___________________

City, State, Zip ____ Cell phone ____________________

What name do you prefer we call you? ____

Whom may we thank for referring you to our office? ____

Have you ever received treatment involving: Gum disease ________ TMJ (jaw) problem ____________

Oral surgery _________ Orthodontics _________________

Occupation ________________________________ Employer _____________________________________

Bus. Address ____

City, State, Zip ____ Bus. Phone _____________________

If you have orthodontic insurance, name of insurance company _________________________________

Group/Policy name ___________________________ Policy number ________________________________

Social Security number (required for insurance)____

For our automated reminder service, choose your contact preference – select one & clearly write number:

Home phone _____________________ or Cell phone __________________________________

E-mail address ____ requested for general office messages,

announcements, and website interactivity

Special requests, considerations or comments ____

____

____

Medical-Dental Questionnaire:

Patient's Name____Date of Birth________________

MEDICAL HISTORY

Patient's Physician________________________Town____________________Phone________________

YES NO

✻ Is your physician currently treating you for any reason?.. ❑ ❑

If yes, please explain____

✻ Have you ever been hospitalized?.. ❑ ❑

If yes, please explain____

✻ Are you currently taking any pills, drugs or other medications?... ❑ ❑

If yes, please list name & reason: 1. ____________________ Reason____________________________

2. ____________________ Reason____________________________

3. ____________________ Reason____________________________

4. ____________________ Reason____________________________

✻ Women, are you pregnant? YES NO If yes, when do you expect? ____________________________

✻ Do you have, or have you ever had, any of the following?

- ❑ 1. Heart disease or chest pains
- ❑ 2. High Blood Pressure
- ❑ 3. Heart Murmur
- ❑ 4. Pacemaker or artificial valves
- ❑ 5. Rheumatic fever
- ❑ 6. Diabetes
- ❑ 7. Blood disorders or anemia
- ❑ 8. Lung or breathing problems
- ❑ 9. Asthma
- ❑ 10. Kidney or liver problems
- ❑ 11. Hepatitis
- ❑ 12.Thyroid problems
- ❑ 13. Stomach or intestinal problems
- ❑ 14. Tuberculosis
- ❑ 15. Arthritis
- ❑ 16. Artificial joint replacements
- ❑ 17. Epilepsy or seizures
- ❑ 18. Syphilis, gonorrhea, AIDS
- ❑ 19. Tumors or cancer
- ❑ 20. Radiation therapy
- ❑ 21. Shortness of breath

✻ If yes to any of the above, please explain____

____

✻ Have you ever been told to take antibiotics before dental procedures?.............................. ❑ ❑

If yes, please explain____

✻ Are you allergic to any medications or drugs?.. ❑ ❑

If yes, please explain____

✻ Do you have any other allergies?... ❑ ❑

If yes, please explain____

DENTAL HISTORY

Patient's Dentist__________________________Town______________________Phone________________

✻ Approximate date of last dental check-up?____________________________________

✻ Do you have discomfort in your teeth or jaw? .... ❑ ❑

If yes, please explain____

✻ Do your joints pop, click or grate when opening widely? .... ❑ ❑

If yes, please explain____

✻ Do you clench or grind your teeth? .... ❑ ❑

I agree to notify you if there is any change in my (child's) health status.

Signature____ Date____________________

ADA American Dental Association® Dental Claim Form

Please complete the highlighted items below:

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)

7. Gender ☐ M ☐ F

8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number

10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)

14. Gender ☐ M ☐ F

15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number

17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)

22. Gender ☐ M ☐ F

23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

34. Diagnosis Code List Qualifier ☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ B ____ C ____ D ____

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X ____________________

Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X ____________________

Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI

50. License Number

51. SSN or TIN

52. Phone Number ( ) -

52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X ____________________

Signed (Treating Dentist) Date

54. NPI

55. License Number

56. Address, City, State, Zip Code

56a. Provider Specialty Code

57. Phone Number ( ) -

58. Additional Provider ID

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