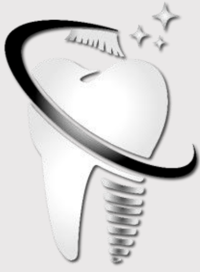

RAPID CITY SMILES

IMPLANT & FAMILY DENTISTRY

DR. DAN GRAVES

PATIENT INFORMATION

FIRST NAME: ________________________________ LAST NAME: _____________________________

DOB: _____________________ CELL PHONE: _____________________________________

ADDRESS: ____ CITY: ___________________

ZIP: ________________ SS#: __________________________________

EMPLOYER: ____

E-MAIL: ____

IN CASE OF EMERGENCY CONTACT: ______________________________ PHONE: _____________

PARENT INFORMATION
IF MINOR-

FIRST NAME: ___________________________________ LAST NAME: ___________________________
DOB___________________ SS#: ____________________________

CURRENT MEDCATIONS:

-
-
-

ANY DISEASE/PROBLEM WE SHOULD KNOW ABOUT? Y / N

ALLERGIES TO MEDICATIONS? ___________________
____
____

DATE OF LAST DENTAL VISIT? _____________________ NAME OF PREVIOUS DENTIST? ________________________

REASON FOR TODAYS VISIT? ____

ARE YOU IN GOOD HEALTH? Y / N DATE OF LAST MEDICAL EXAM: _________________

HAVE YOU HAD A HIP OR JOINT REPLACEMENT? Y / N
DO YOU REQUIRE A PRE-MEDICATION BEFORE DENTAL APPOINTMENTS? ______________

HOW DID YOU HEAR ABOUT OUR OFFICE? ____

PATIENT HEALTH HISTORY

PLEASE CHECK IF YOU HAVE A HISTORY OF THE FOLLOWING:

A.I.D.S./HIV POSITIVE _____
ALCOHOLISM _____
ANEMIA _____
BLOOD DISEASE _____
BONE DISEASE _____
CANCER _____
CHEMICAL DEPENDENCY _____
CHEST PAIN ______
CIRCULATORY PROBLEMS _____
CONVULSIONS/SEIZURES _______
DIABETES _______

EXCESSIVE BLEEDING ____
EQILEPSY _____
HEAD INJURIES ____
HEARING IMPAIRED _____
HEART DISEASE____
HEART VALVE, MURMUR ______
HIGH BLOOD PRESSURE _____
HPV ______
JAUNDICE _____
KIDNEY DISEASE _____
LATEX SENSITIVITY _____

LUPUS ______
LOW BLOOD PRESSURE ______
MITRAL VALVE PROLAPSE ______
NECK & BACK PROBLEMS ______
NERVOUS PROBLEMS _____
PACEMAKER _______
PROSTHETIC JOINTS _____
PSYCHIATRIC CARE ____
RADIATION TREATMENT _____
RESPIRATORY PROBLEMS _____
SEIZURES/FAINTING SPELLS _____

SINUS PROBLEMS _____
STOMACH ULCERS ____
STROKE _____
THYROIDE DISEASE ____
TUMORS ______
ULCERS _____

DO YOUR GUMS BLEED WHEN YOU BRUSH? Y / N

HAVE YOU OR A FAMILY MEMBER EVER BEEN TREATED FOR PERIODONTAL DISEASE? Y / N

HAVE YOU EVER HAD COMPLICATIONS FROM AN EXTRACTION? Y / N

HAVE YOU EVER HAD A POPPING OR CLICKING NEAR YOUR EAR WHEN YOU CHEW? Y / N

ARE YOU PRONE TO FRQUENT HEADACHES? Y / N

DO YOU GRIND OR CLENCH YOUR TEETH? Y / N

HAVE YOU EVER HAD ORTHODONTIC TREATMENT? Y / N

DO YOU SNORE? Y / N

DO YOU HAVE PROBLEMS WITH BAD BREATH? Y / N

DO YOU USE AN ELECTRIC TOOTHBRUSH? Y / N

ARE YOUR TEETH SENSITIVE TO HOT, COLD OR PRESSURE? Y / N

WOMEN ONLY- ARE YOU PREGNANT? Y / N EXPECTED DELIVERY DATE: ______________

ON A SCALE FROM 1 TO 10, 10 BEING THE HIGHEST, HOW IMPORTANT IS YOUR DENTAL HEALTH?

1 2 3 4 5 6 7 8 9 10

I certify that I have read and understand the questions, above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist of any other members of his/her staff responsible for any errors that I have made in the completion of the form.

Adult/Guardian: I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or x-rays, as may be deemed necessary by the doctor.

Patient: ____ Date: ____________________

Parent/Guardian (if patient is a minor): ____

PAYMENT ARRANGEMENT FORM

Name of Patient: ____

PAYMENT AGREEMENT

I agree that I am responsible for all services rendered to the patient and that payment is due and payable to the practice at the time services are rendered and that health, dental and accident insurance policies are an arrangement between my insurance carrier and me.
I agree to pay all deductible and co- pays at the time of service (if I have dual insurance coverage, my co-pay or deductible will be based on my primary coverage.) I understand that while the practices will file claims with my insurance company on my behalf, I remain responsible to the practice for what is not paid by my insurance company. I also understand that if the practice cannot verify insurance benefits eligibility for me prior to treatment that I will pay in full for the services at the time they are rendered.
I understand that the practice may charge:
1) A late fee if payment on my account is not received by due date
2) an amount equal to $35.00, but no to exceed the maximum amount permitted by law for each returned check.
3) A $35 fee for each appointment that is missed/canceled without at least 24 hours advanced notice.

I agree to the extent permitted by law, that if my account balance is referred to any agency or attorney for collection purpose, to pay reasonable attorney fees and any expenses or cost relating to the collection proceeding, including court cost. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable. I authorize payment directly to the practice.
Statements that are not paid in full after 90 days from date of service will be turned over to our collection agency with a added $200 fee.

RESPONSIBLE PARTY:

Full Name: ____ DOB: ______________________

SSN# ____________________________________

INSURANCE INFORMATION:

Primary insurance name: _______________________________ Phone number: ____________________________

Name of insured: _____________________________________ Relationship: _________________________

DOB: ____________________________ ID # _____________________________________ Group # ____________

Secondary insurance name: _____________________________ Phone number: _____________________

Name of insured: _____________________________________ Relationship: _______________________

DOB: ___________________________ ID# _________________________________ Group #______________