



Reeves Cosmetic Dentistry
AT GREYSTONE

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date: _____ Home Phone: () _____ Cell Phone: () _____ Email _____

Last Name: _____ First Name: _____ Mid. Initial _____ Soc. Sec.: _____

Address: _____

City: _____ State: _____ Zip: _____

Sex: M or F Age: _____ Birth date: _____ Single Married Separated Divorced

Patient Employed by: _____ Occupation: _____

Business Address: _____ Bus. Phone: () _____

Whom may we thank for referring you? _____

In case of an emergency, who should be notified? _____ Phone () _____

Form of payment for today's visit? Cash Check Credit Card

PRIMARY DENTAL INSURANCE

Dental Insurance: yes _____ no _____

Person Responsible for Account: Last Name: _____ First: _____ Initial _____

Relationship to Patient: _____ Birth date: _____ Soc. Sec.#: _____

Address (if different from patient): _____ Phone () _____

City: _____ State: _____ Zip: _____

Person Responsible is Employed By: _____ Occupation: _____

Business Address: _____ Business Phone () _____

Dental Insurance Company: _____ Policy Holder _____

Contract # _____ Group # _____ Subscriber # _____

Name(s) of dependent(s) covered under this plan: _____



Reeves Cosmetic Dentistry
AT GREYSTONE

Welcome to our office. We are honored that you have chosen us as your dental healthcare provider. We will do the best we can to make your appointment a convenient and pleasant experience. We are committed to providing you with the best possible care. If you have dental insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our office policies.

1. Your balance is due at the time services are rendered less your estimated insurance unless other payment arrangements have been approved, in advance, by our staff. We accept payment for services in cash, check, MasterCard or Visa. (please initial) _____
2. If you have dental insurance, we will be happy to file your insurance for you. All insurance benefits that we give to you are estimates. We are not able to guarantee what your insurance company decides to pay or not to pay. We file insurance as a courtesy for you and we will do our best to maximize the benefit you receive from the insurance company.
3. For extensive treatment, we offer an accounting courtesy for treatment paid in full prior to the service. We will always clarify financial arrangements prior to treatment.
4. In the event that payment is not made for services after a reasonable period of time, our attorney will be advised and formal action to collect will be initiated. You will be responsible for any attorney's fees and/or collection charged incurred.
5. As a courtesy to our patients, we have extended financing available through Capitol One. This is a resource available to you if you need it. Please ask your treatment coordinator if this resource may be something you are interested in.
6. Fees quoted are accepted for 90 days. In the event that clinical conditions warrant a different treatment, you will be notified of changes in fees prior to proceeding with the procedure.
7. Balances older than 30 days will be subject to interest charges of 1.5% per month, or 18% annually.
8. A \$25.00 NSF fee will be charged for all returned checks.
9. Broken appointments and appointments canceled with less than 24 hours advance notice will be subject to a broken appointment or last minute cancellation fee. This is to help accommodate other patients as well as our team in making sure we manage our time efficiently.

Insurance

The process of utilization and quality of insurance has changed much over the years. We will do our best to help you understand and maximize your benefits. The amount of coverage your insurance provides is strictly a function of the policy selected by you and your employer.

Note: Your insurance is a contract between you, your employer and the insurance carrier. We are not a party to that contract. If you have a problem with your insurance coverage, we ask that you speak directly to your insurance company. Your charges in our office are your responsibility from the date the services are rendered. We do not base your diagnosed treatment on your insurance coverage. We base it on your need and desires. We take pride in the quality care we offer our patients and make every effort to have your dental visits with us be as comfortable as possible.

Thank you for reviewing our financial policy. We encourage you to ask questions if there is a policy or procedure you are not certain about. We appreciate the opportunity to serve you and we take that responsibility very serious. The best Patient-Doctor relationships are maintained when there is a complete understanding to the treatment rendered and the fee for that treatment. If you have any questions, please ask us.

I have read, understand and agree to abide by this policy. I have been given the opportunity to receive a copy of this document.

Signature _____ Date _____ Witness _____ Date _____



DENTAL HISTORY

Reason for today's visit? _____

Former dentist: _____ Phone (_____) _____

Date of last dental care: _____ Date of last dental X-Rays: _____

Please put a check in the box if you have had problems with any of the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or fillings | <input type="checkbox"/> Sensitivity when chewing |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sores or growths in your mouth |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Teeth sensitivity to cold or heat | <input type="checkbox"/> Do you breathe through your mouth while awake or asleep |
| <input type="checkbox"/> Smoke / Chew tobacco | <input type="checkbox"/> Bite lips or cheeks regularly | |

How often do you floss? _____ How often do you brush? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical procedure? Yes No

Is there any more information about your dental health or previous treatment?

MEDICAL HISTORY

Physician's name: _____

Have you ever had any serious illness or operation(s)? Yes No If yes, describe: _____

Have you ever had a blood transfusion? Yes No If yes, give approximate date(s): _____

(Women) Are you pregnant? Yes No Nursing Yes No Taking birth control Yes No

Medical alerts? _____

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough Up Blood | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | Describe _____ | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Venereal Disease |

Any medications in the last two years? Yes No If yes, list: _____

List medications you are currently taking? _____

Allergies? _____ Any adverse reactions to medications taken (ever)? Yes No

Do you use two or more pillows to sleep? Do you have any condition or disease not listed? Yes No

Please list: _____

AUTHORIZATION

I have reviewed the information of this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and helpful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay the dentist all the insurance benefits otherwise payable to me for the services rendered. I authorize the use of this signature on all insurance submissions. Insurance is also filed and accepted as a courtesy.

I authorize the dentist to release all information that is necessary to secure the payments of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. Please note that accounts over 30 days old are considered past due and are subject to a 1.5% finance charge monthly. Dr. Reeves, at his discretion, may place the unpaid account with an attorney for collection. In the event an account is turned over to an attorney, the patient or person responsible for the patient's account agrees to pay an attorney fee, court costs and any other reasonable costs of collection.

SIGNATURE: _____ DATE: _____