WELCOME

ARLINGTON DENTAL GROUP

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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 questions we will be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____
Social Security Number _____
Date of Birth _____
Male _____ Female _____ Minor _____ Single _____ Married _____ Widowed _____ Divorced ____
Notify in Case of Emergency _____ Phone _____
Refered By _____

Telephone

Home Phone _____
Work Phone _____ Ext. _____
Cell Phone _____
Where do you prefer to receive calls? Home _____ Work _____ Cell _____
Email Address_____

Responsible Party

Name _____
Social Security Number _____
Date of Birth _____
Mailing Address _____
City _____ State _____ Zip Code _____
Relationship to Patient _____

Insurance Information

Primary
Subscriber Name _____
Social Security Number _____
Date of Birth _____
Employer _____
Insurance Company _____
Patient ID# _____ Group# _____

Secondary
Subscriber Name _____
Social Security Number _____
Date of Birth _____
Employer _____
Insurance Company _____
Patient ID# _____ Group# _____

Dental History (For New Patients Only)

Do you like your smile ? Yes _____ No _____
If no, what would you change? _____

Do you now or have you ever experienced pain/discomfort in the jaw joint? (**TMJ/TMD**) Yes _____ No ____
Do you smoke or use smokeless tobacco? Yes _____ No_____ Date Quit _____
Do you currently whiten your teeth? Yes _____ No_____
If no, would you be interested in whitening? _____
Name of previous Dentist _____ Phone# _____
Date of last exam _____
Reason for leaving _____

Medical Information

Physician's Name _____ Office Phone _____

Women Are you pregnant? _____ Do you take birth control?_____

Check if you have any of the following conditions

_____ Anemia
_____ Artificial Heart Valve
_____ Artificial Joints
_____ Asthma
_____ Abnormal Blood Pressure
_____ Cancer / Chemotherapy
_____ Chemical Dependency
_____ Circulatory Problems
_____ Cold Sores / Oral Herpes
_____ Cortisone Treatment
_____ Diabetes
_____ Epilepsy
_____ Glaucoma
_____ Heart Murmer
_____ Other_____

_____ Heart Problems
_____ Hemophilia / Prolonged Bleeding
_____ HIV / AIDS
_____ Kidney Disease
_____ Liver Disease (Hepatitis)
_____ Material Allergy (latex)
_____ Mitral Valve Prolapse
_____ Pacemaker / Heart Surery
_____ Respiratory Disease
_____ Rheumatic Fever
_____ Stroke
_____ Tuberculosis
_____ Ulcer
_____
_____

Allergies _____
_____
Current Medications _____
_____
Any other medical information _____
_____
_____
_____

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

Signature _____ Date _____

Signature _____ (For Update) Date _____

Patient Name_____

Insurance Authorization

I authorize the insurance company, that I have indicated on the information form, to pay Arlington Dental Group any and all benefits that would otherwise be payable to me for services rendered. I also authorize the use of this signature on all insurance submissions.

Signature _____ Date _____

Account Authorization

I authorize Arlington Dental Group and staff to release all information necessary to secure payment. I understand that I am financially responsible for all charges whether or not paid by my insurance. If my account should become delinquent, I will be responsible for all expences involved in collection effort, including but not limited to, attorney's fees, court costs, and collection fees.

Signature _____ Date _____

Contact Authorization

I authorize Arlington Dental Group to call me at all number(s) I have indicated on the information form in efforts to contact me. I may be contacted for reasons including but not limited to, reminder phone calls, appointment changes, collection efforts, and insurance inquiries.

Signature _____ Date _____

Appointment Failure and Short Notice Cancel Notification

I understand that if I fail to show up for an appointment my account will be charged a fee of $35.00 for each appointment missed. I also understand that if I cancel an appointment without giving at least 24 hours notice my account will be charged a fee of $25.00 for each appointment canceled.

Signature _____ Date _____

*You may refuse to sign Appointment Failure And Short Cancel Notification, however, it is our office policy and DOES apply to you.

Understanding My Insurance

Arlington Dental Group appreciates the confidence you have shown in choosing us to provide your dental care needs. The services you elect to receive, implies a financial responsibility on your part. The responsibility obligates you to ensure payments in full of our fees. As a courtesy, we will bill your insurance carrier/s on your behalf. However, you are ultimately responsible for your bill.

Many insurance companies have many stipulations that may affect your coverage. It is ultimately the patient's responsibility to know your coverage and benefits. As a service to you, every attempt will be made to determine your level of eligibility, covered services, amounts payable, co-payments, deductibles and plan maximums. Plan maximums are the total amount of benefits an insurance company will pay annually and in some cases for a lifetime. This determination will be based on the dental insurance information you have provided to us.

Any planned services over $300.00 should be pre-determined. This is a process where the dentist submits a treatment plan to the payer/insurance company before the treatment begins. The payer/insurance company determines how the services will be covered. Upon a mutual financial agreement between the patient and the dentist, treatment may commence. Pre-determination is not a guarantee of payment, but an estimate of the benefits available for the proposed services to be rendered. Submission of additional claims, from our office or any other dental office; prior to the final payment of the pre-determined service, may affect the proposed payment.

Insurance benefits provided by an employer were negotiated via the employer and insurance company. Not all recommended dental services may be covered by your policy, but does not mean that it is not a dental necessity for good oral health. This being stated, there may be extenuating circumstances in which your coverage may go beyond the scope of your plan. For example: a dental accident, heart disease, diabetes, or pregnancy may warrant additional dental benefits.

Co-payment and deductibles are due at the time of service. If you are unable to render payment at the time of service, we can help you seek payment options through our financial payment program: *CARE CREDIT,* or reschedule your appointment for a better time.

If you have a specific question about your dental insurance, please contact your human resources or insurance company as listed on your dental policy.