Darling Dental

Patient Information:

Date: _____

Name: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____Cell Phone: _____

Email address: _____ How would you like to be contacted? _____

Marital Status: □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated

Patient's Employer: _____

Spouse or Parent/Guardian's Name: _____

Employer:_____ Work Phone: _____

Person to contact in case of emergency: _____

Relationship: _____Phone #_____

Dental Insurance: Yes or No

Insurance Company:_____ Insured's Name: _____

Insured's SSN or ID# : _____ Insured's DOB: _____

Insurance Company's phone number: _____

Responsible Party:

Name of person responsible for this account: _____

Relationship to patient: _____

Address:_____

Home Phone: _____Cell Phone: _____

Work Phone: _____ Birthdate: _____

Employer: _____

Is this person currently a patient in our office? Yes No

Payment is expected at each appointment. For your convenience, we offer the follow methods of payment.

Cash, all major credit cards and Care Credit

How did you hear about our office? Darling Dental website, Delta Dental website,

friend (we'd like to thank him/her), other: _____

Patient Medical History

Patient Name: _____

Physician: _____ Office Phone: _____

Date of last exam: _____

Please Circle Yes or No

1. Are you under medical treatment now? **Y / N**
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain_____ **Y / N**
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? **Y / N**

_____

4. Have you ever taken Fen-Phen/Redux? **Y / N**
5. Do you use tobacco? **Y / N**
6. **Are you pregnant**? **Y / N**
7. **Are you allergic to or have you had any reactions to the following**?

Local Anesthetics (e.g. Novocain)	Penicillin or any other Antibiotics
Sulfa Drugs	Barbiturates
Sedatives	Iodine
Aspirin	Any metals (e.g. nickel, mercury, etc.)
Latex rubber	Other:_____

8. Please circle if you have or have had any of the following:

High Blood Pressure	Leukemia	Angina	Easily Winded
Heart Attack	Diabetes	Stroke	Frequently Tired
Rheumatic Fever	Kidney Disease	Hay Fever	Tuberculosis
Swollen Ankles	AIDS/HIV	Anemia	Radiation Therapy
Fainting/Seizures	Thyroid Problem	Emphysema	Glaucoma
Asthma	Heart Disease	Cancer	Recent Weight Loss
Low Blood Pressure	Cardiac Pacemaker	Arthritis	Liver Disease
Epilepsy/Convulsions	Heart Murmur	Heart Trouble	Chest Pains
Mitral Valve Prolapse	Cold Sores	Respiratory Problems	
Stomach Troubles/Ulcers	Other, please explain:_____		

OVER >>>>

Medical History Updates: _____ **Date:**_____

_____ **Date:**_____

_____ **Date:**_____

Patient Dental History

Name of Previous Dentist and Location_____Date of Last Exam_____

Please Circle Yes or No

1. Do your gums bleed while brushing or flossing? **Y / N**
2. Are your teeth sensitive to hot or cold liquids/foods? **Y / N**
3. Are your teeth sensitive to sweet or sour liquids/foods? **Y / N**
4. Do you feel pain to any of your teeth? **Y / N**
5. Do you have any sores or lumps in or near your mouth? **Y / N**
6. Have you had any head, neck or jaw injuries? **Y / N**
7. Have you ever experienced any of the following problems in your jaw?

   Clicking Pain (joint, ear, side of face) Difficulty in opening or closing Difficulty in chewing
8. Do you have frequent headaches? **Y / N**
9. Do you clench or grind your teeth? **Y / N**
10. Do you bite your lips or cheeks frequently? **Y / N**
11. Have you ever had any difficult dental extractions in the past? **Y / N**
12. Have you ever had any prolonged bleeding after dental extractions? **Y / N**
13. Have you had any orthodontic treatment? **Y / N**
14. Do you wear dentures or partials? If yes, date of placement _____ **Y / N**
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? **Y / N**
16. Do you like your smile? **Y / N**
17. Do you have any chief concerns regarding your smile/oral health? Please explain:

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient (Or parent/guardian if minor)

X_____

Print Name (Or parent/guardian if minor)

X_____

Signature of treating dentist

TMJ HEALTH QUESTIONNAIRE

Please answer all questions to the best of your ability.

CHIEF CONCERN or N/A_____

DATE OF ONSET or N/A_____

JAW JOINT SYMPTOMS

Do you have pain in your jaws? Right, left or both	Y	N	Does your jaw feel tired after a big meal?	Y	N
Are you capable of chewing gum?	Y	N	Are there any foods you avoid eating?	Y	N
Are you capable of chewing a bagel?	Y	N	Do you have difficulty opening wide or yawning?	Y	N
Do you hear noises in your jaw joint	Y	N	Do you ever get dizzy?	Y	N
Has your jaw ever locked open or closed?	Y	N	Does your jaw ache when you open wide?	Y	N
Can you make your jaw pop or crack?	Y	N	Do you ever feel faint?	Y	N
Is there a family history of jaw joint (TMJ) problems or headaches?	Y	N	Do you ever feel nauseated?	Y	N

PAIN SYMPTOMS

Do you get headaches?	Y	N	Do you get headaches in the right or left temple areas?	Y	N
Do you get migraine headaches?	Y	N	Do you get headaches in the front or back of your head?	Y	N
Do you frequently have neck aches or stiff neck muscles	Y	N	Do you clench your teeth during the day?	Y	N
Have you ever had chronic shoulder or back pain?	Y	N	Do you think you clench your teeth at night?	Y	N
Do you have trouble sleeping soundly?	Y	N	Do you think you grind your teeth when asleep?	Y	N
Are your jaws tired when you awaken?	Y	N	When are your pain symptoms the worst?		
Are your teeth sore when you awaken?	Y	N			
Have your wisdom teeth been extracted?	Y	N	Does anything make you feel better?		

What medications, if any, are you taking? _____

How often do you take medication for relief of pain? _____

TRAUMA OR ACCIDENTS

Have you ever had a severe blow to the head or jaw	Y	N	Have you ever been involved in any serious accidents, such as a car accident?	Y	N
Any whiplash neck injuries	Y	N	Details: _____		

EAR AND EYE SYMPTOMS

Do you have pain in either ear?	Y	N	Do you wear glasses or contacts?	Y	N
Do you suffer from any loss of hearing?	Y	N	Are there times when your eyesight blurs?	Y	N
Do you have itchiness or stuffiness in either ear?	Y	N	Do you get pain in, around or behind either eye?	Y	N
Do you hear ringing, buzzing, or hissing sounds in either ear?	Y	N			

BREATHING

Do you have allergies?	Y	N	Is your nose stuffed when you don't have a cold?	Y	N
Do you have sinus problems?	Y	N	Have you been diagnosed with Sleep Apnea?	Y	N
Do you snore at night?	Y	N	Have you had a sleep study done at a Sleep Clinic (hospital)?	Y	N

Darling Dental

Nathan S. Darling, D.D.S.

7161 N. Port Washington Rd

Glendale, WI 53217

414-247-1470

FINANCIAL POLICY & INSURANCE INFORMATION

Payment is due at the time of service. If you have dental insurance, your co-pay and/or deductible is due at the time of service. Patients without dental insurance are expected to make full payment at the time of service. We accept cash, all major credit cards and Care Credit.

A Word About Dental Insurance:

As a courtesy, Darling Dental is happy to submit insurance claims for you. However, we remind you that **your policy is an agreement between you and your insurance company, not between your insurance company and our office.** Our fees may be above or below the "usual and customary" fee provided to you by your insurance company. This may have an effect on the amount you will be responsible for. We can make no guarantee of any estimated coverage, but we'll do our best to see that you receive your maximum benefits. Please keep in mind that you are responsible for your total obligation should your insurance benefits result in less coverage than anticipated.

Pretreatment Estimates:

If you would like a treatment plan estimate or pre-treatment estimate sent to your insurance, please ask.

Please turn over >>>>>>>

Broken Appointments:

We respect your time and always make every effort to remain on schedule. For this reason, we schedule only one person at a time. This allows the doctor to provide personalized care. We have set this time aside exclusively for you. If you are unable to keep an appointment, kindly give us **48-hour** notice. This courtesy on your part makes it possible to give your canceled appointment time to another patient in need of care. A minimum fee of $25.00 will apply to a broken appointment or a canceled appointment without a 48-hour notice.

Overdue Accounts:

Since our office is not equipped to handle overdue accounts, any account that reaches 90 days, will be sent to a collection agency. You will be responsible for any additional charges involved in the collection of your account, which could be 33.33%-50% of your total balance. An account will not be sent if prior financial arrangements have been made and you are complying with that agreement.

If you have any questions concerning our office financial policy, please discuss them with us before treatment is performed.

I have read and understand **Darling Dental's** financial policy and agree to the terms and conditions stated.

_____ _____

Patient/Guarantor Signature Date

OR

_____ _____

Parent/Guardian Signature Date