



Welcome!

We are dedicated to the concept that all people have the opportunity to retain their teeth throughout their lifetime with optimum health, function, comfort and esthetics. We realize the importance of your smile and are committed to offering the best that dentistry has to offer—providing quality restorative dentistry with special emphasis on cosmetics. Thanks for coming.

**PATIENT INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
 Gender  F  M Marital Status  Married  Unmarried  
 Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_  
 E-mail Address \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone (\_\_\_\_) \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_  
 Names of family members who use our services \_\_\_\_\_  
 Who referred you to our office? \_\_\_\_\_

**IN CASE EMERGENCY**

Closest friend or relative (not living with you) \_\_\_\_\_  
 Home Phone (\_\_\_\_) \_\_\_\_\_ Daytime Phone (\_\_\_\_) \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_  
 Spouse's Employer \_\_\_\_\_ Spouse's Occupation \_\_\_\_\_  
 Daytime Phone (\_\_\_\_) \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_  
 Business Address \_\_\_\_\_

**INSURANCE INFORMATION**

Name of Subscriber (Name insurance is listed in.) \_\_\_\_\_  
 Subscriber's Birth Date \_\_\_\_\_ Subscriber I.D.# \_\_\_\_\_  
 Group/Policy# \_\_\_\_\_  
 Subscriber's Address \_\_\_\_\_  
 Subscriber's Employer \_\_\_\_\_  
 Patient's relationship to insured:  Self  Spouse  Child  Other  
 Insurance Plan Name \_\_\_\_\_

*Delta Dental Policy: Dr. Reynolds is considered an "out-of-network" provider with ALL insurance companies due to our "out-of-network" status, Delta Dental has informed us all re-imbursments will be sent to the subscriber. This means your insurance company will mail payments directly to you. In order to simplify the filing process we ask that you provide us with your dental insurance information. This will give us the ability to print a claim and you (the patient) are not required to fill out any extra forms. To receive your re-imbursment you will simply mail the insurance claim form to the insurance company. They will process your claim and send payment to you. NOTE: Patients using Delta Dental insurance are required to pay in full at the time of their visit.*

Insurance Plan Address for DENTAL claims \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Insurance Phone (\_\_\_\_) \_\_\_\_\_ Do you have a secondary insurance plan?  Yes  No

**ACCOUNT INFORMATION**

Guarantor of Account \_\_\_\_\_

Address (if different from above) \_\_\_\_\_

How will payment of your account be handled?  Cash  Check  MC/VISA/DISCOVER

We file insurance as a courtesy to our patients. However, we are not considered in-network providers for any insurance plan. We will be considered an out-of-network provider. Verification of coverage and benefits is the responsibility of the patient.

We allow 60 days for insurance to reimburse for treatment. Any balance after the 60 day grace period becomes the patient's responsibility. If any claim expires due to inaccurate information or non-current information, the balance becomes the patient's responsibility. Any re-submissions to the insurance company will be carried out by the patient.

**Secondary Insurance:**

Our office does not file secondary insurance. This is the responsibility of the patient. When estimating patient portions secondary insurance will not be calculated in determining your payment due. However, we will provide you will the necessary paperwork in order to make filing your claim more convenient.

**How to file the claim. . .**

As a courtesy, we will provide you with a completed secondary insurance claim form. Once you receive the Explanation of Benefits (EOB) from your primary insurance carrier you will have all materials needed to submit to your secondary insurance carrier. Simply attach a copy of the primary EOB to the secondary claim form and submit to the claims mailing address (found in upper right-hand corner of claim form).

**Your reimbursement. . .**

In most cases you should receive your reimbursement within two to four weeks of the date that you submit the claim. If you haven't received it by that time, contact your insurance representative to find out why.

I understand that the financial responsibility for dental services provided in this office for myself and/or my dependents is mine. I further understand that a finance charge may be added to any past due balance. In the event of default. I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_



## CHILD'S DENTAL HISTORY *(Under the age of 18)*

Child's Last Name \_\_\_\_\_ Child's First Name \_\_\_\_\_

What prompted you to seek dental care for your child at this time? \_\_\_\_\_

Date of last cleaning and exam? \_\_\_\_\_

Has your child had any difficulty accepting dental treatment previously?  Yes  No If so, please explain \_\_\_\_\_

Name of previous dentist \_\_\_\_\_ Phone \_\_\_\_\_

### MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Last Visit \_\_\_\_\_

Phone \_\_\_\_\_

Is your child being treated by a physician now?  Yes  No If so, what? \_\_\_\_\_

Taking any medication?  Yes  No If so, what? \_\_\_\_\_

Allergic to any medication?  Yes  No If so, what? \_\_\_\_\_

Has your child had any Recent Illness?  Yes  No If so, what? \_\_\_\_\_

### PERSONAL HISTORY (check all that apply):

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> AIDS                | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Iodine Allergy        | <input type="checkbox"/> Radiation Treatment  |
| <input type="checkbox"/> Allergies           | <input type="checkbox"/> Dilantin Allergy     | <input type="checkbox"/> Jaundice              | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Amoxicillin Allergy | <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Keflex Allergy        | <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> Ampicillin Allergy  | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Rheumatism           |
| <input type="checkbox"/> Anaprox Allergy     | <input type="checkbox"/> Epinephrine          | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Sinus Problems       |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Erythromycin Allergy | <input type="checkbox"/> Local Anes. Allergy   | <input type="checkbox"/> Stomach Problems     |
| <input type="checkbox"/> Anti-inflammatories | <input type="checkbox"/> Excessive Bleeding   | <input type="checkbox"/> Lorocet Allergy       | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Mental Disorders      | <input type="checkbox"/> Sulfa Allergy        |
| <input type="checkbox"/> Artificial Joints   | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Mercury Allergy       | <input type="checkbox"/> Tetracycline Allergy |
| <input type="checkbox"/> Aspirin Allergy     | <input type="checkbox"/> Growths              | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems     |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Hay Fever            | <input type="checkbox"/> Morphine Allergy      | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Bactrim             | <input type="checkbox"/> Head Injuries        | <input type="checkbox"/> Motrin Allergy        | <input type="checkbox"/> Tumors               |
| <input type="checkbox"/> Blood Disease       | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Nervouse Disorders    | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Venereal Disease     |
| <input type="checkbox"/> Codeine Allergy     | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Penicillin Allergy    |   |
| <input type="checkbox"/> Demoral Allergy     | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Percodan Allergy      |   |

Thank you for your cooperation. If there is any other information which you feel would be a value, please let us know.

I understand that the information above is necessary to provide my child with dental care in a safe and efficient manner. To my knowledge answers are correct and complete. Realizing that the use of anesthetic agents embodies certain risks, I will inform this office of any changes in my child's medical history. I further authorize and consent that Doctor Reynolds and/or his assigned may utilize diagnostic aids deemed appropriate and perform all forms of treatment, medication, and therapy deemed necessary in connection with the dental care of (Name of Patient) \_\_\_\_\_ until written notice is given discontinuing this permission.

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_