



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 _____



DENTAL HISTORY *(for adults 18yrs or older)*

Last Name _____ First Name _____

Date of last cleaning and exam? _____

Have you ever had: Orthodontics if so, were you a Child or Adult; Periodontal (Gum) Surgery; or
 Other Major Dental Treatment

Why have you come to JA Reynolds DDS? Please explain _____

Name of previous dentist _____ Phone _____

Are you dissatisfied with any previous dentistry service you have had? Yes No If yes, why? _____

Do you use tobacco? Cigarettes Smokeless Tobacco

Do you have any areas where food impacts around your teeth? Yes No

Do your gums tend to: Bleed Easily Feel Tender Irritated

Are your teeth sensitive to: Hot Cold Pressure Sweets

Do you have pain in your: Head Neck Shoulder Upper Back

Do you have any: Popping Clicking Other noises in your jaw joints

Are you aware of: Grinding Your Teeth Clenching Your Teeth

List any other problems you may be having: _____

Yes No

Have you ever had local anesthetic (novocaine) for dental purposes?

Have you ever had nitrous oxide (laughing gas)?

Have you ever had any negative reactions to a dental injection or nitrous oxide?

Have you ever been anxious or nervous about dental treatment?

COSMETICS

What would you like to do to improve your smile? Whiten Teeth Straighten Teeth Change Size/Shape

Other Interests _____

MEDICAL HISTORY

Physician's Name _____ Last Visit _____

Phone Number (____) _____

Yes No

Are you being treated by a physician presently? If so, for what _____

Have you ever required hospitalization? If so, for what? _____
When? _____

Are you prone to dizziness or fainting spells?

FOR WOMEN ONLY

Yes No

- Are you pregnant? If so, when are you due? _____
- Are you nursing?
- Are you presently taking birth control pills?

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"/> Nervouce 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 | |

MEDICAL HISTORY

Yes No

- Are you taking any medications? If so, list below

Name of Drug	Dosage	Reason for taking	How long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this form you will consent to our use and disclosure of protected health information to carry out treatment, payment activities, and healthcare operations.

I understand that the information above is necessary to provide me 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 medical history.

I further authorize and consent that Dr. Reynolds and/or his assigned may utilize diagnostic aids deemed appropriate and preform 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.

Signature _____ Date _____