SKINNERDENTAL
HEALTHY SMILES TO LAST A LIFETIME

PATIENT INFORMATION

First Name: _____MI: _____ Last:_____ Nick Name:_____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
DOB: _____ Sex: M F SS#: _____ E-mail Address:_____
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Address: _____ City:_____ State: _____ Zip: _____
Occupation: _____ Employer: _____
Business Address: _____Business Phone _____
How did you hear about our office? _____
In case of emergency, who should be notified? _____ Phone #_____

FINANCIAL INFORMATION

Person Responsible for Account First Name: _____ MI: _____ Last:_____
Relationship to Patient: _____ SS#:_____
Address: _____ City:_____ State: _____ Zip: _____
Occupation: _____ Employer: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Relative of Responsible Party (not at same address): _____ Phone:_____

Financial Agreement

- Payment in full by cash, check or credit card on the day of treatment
- Dental Insurance - ESTIMATED PORTIONS ARE DUE ON DAY OF TREATMENT
  (After insurance claim is processed, I will pay in full, any balance remaining)

Should your account be turned over for collection, the undersigned agrees to pay all cost to collect the debt, including, but not limited to, interest in the amount of 18% per annum, attorney's fee, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party debt collection agency.

XSignature: _____ Date: _____

INSURANCE INFORMATION

If you have insurance, please be aware that our financial relationship is with our patients and their families, not their insurance company. You are responsible for all payments regardless of your insurance coverage. We will be happy to help in every way we can in filing your claim. Please provide us with current and complete information regarding your insurance company's name, address, plan number and identification number of the insured.

Primary Insurance Co: _____Plan or Group:_____
Adress:_____ Insured's name: _____
Insured's Social Security or ID number: _____ Insured DOB: _____

Secondary Insurance Co: _____ Plan or
Group:_____
Adress:_____ Insured's name: _____

I hereby release any information regarding this account to the insurance company, and assign any dental benefits to be paid directly to Dr. Skinner by the insurance company.

XSignature: _____ Date: _____

SKINNER DENTAL
HEALTHY SMILES TO LAST A LIFETIME

HEALTH HISTORY

Insured's Social Security or ID number: _____ Insured DOB: _____

1) Are you you under a physician's care now? Yes No If Yes _____
Hospitalization or major operation? Yes No If Yes _____
Have you ever taken Fosamax, Boniva, or any other medications containing bisphonsphonates? Yes No If Yes _____

2) Are you taking or have you recently taken any prescription, OTC or herbal mediation?
Yes No If yes, please list here: _____

3) Are you ALLERGIC to or have you reacted adversely to any of the following medications?

Aspirin	YES	NO	Latex	YES	NO
Codeine	YES	NO	Metal	YES	NO
Penicillin	YES	NO	Sulfa Drugs	YES	NO
Local Anesthetics	YES	NO	Acrylic	YES	NO

4) Do you have or have you had ANY of the following:

YES	NO	Heart Disease	YES	NO	Ulcers	YES	NO	Epilepsy
YES	NO	Heart Surgery	YES	NO	Diabetes	YES	NO	Fainting/Seizures
YES	NO	Congenital Heart Lesions	YES	NO	Thyroid Problems	YES	NO	Persistent Headaches
YES	NO	Heart Arrhythmia	YES	NO	Arthritis	YES	NO	Anemia
YES	NO	Pacemaker/Defibrillator	YES	NO	Joint Replacement	YES	NO	Abnormal Bleeding
YES	NO	High Blood Pressure	YES	NO	Osteoporosis	YES	NO	Bruise easily
YES	NO	Stroke/TIA	YES	NO	Tumor/Growths	YES	NO	AIDS/HIV
YES	NO	Respiratory Problems	YES	NO	Alcoholism/Drug Abuse			Women Only:
YES	NO	Asthma	YES	NO	Radiation/Chemo	YES	NO	Are you pregnant
YES	NO	Persistent Cough	YES	NO	Nervousness	YES	NO	Contraceptives

DENTAL HISTORY

YES	NO	Hay Fever/Allergies	YES	NO	Glaucoma	YES	NO	Reached Menopause
YES	NO	Sinus Problems	YES	NO	Hepatitis/Jaundice	YES	NO	Hormone Replacement

1) Primary reason for this dental appointment: _____
2) Date of last dental exam & cleaning? _____
3) Date of last x-rays?_____
4) What would you like to improve about your dental health or smile? _____
5) Are you interest in straightening your teeth or closing any spaces?_____
6) Do you or have you had any of the following:

Yes	No	Mouth Discomfort	Yes	No	Tired Jaw or Facial Muscles	Yes	No	Difficulty Chewing
Yes	No	Bleeding Gums	Yes	No	Bad Taste or Bad Breath	Yes	No	Grinding/Clenching Teeth
Yes	No	Sensitive Teeth	Yes	No	Complications with Dental Treatment			

I certify that my answers to the health and dental questions are accurate and correct to the best of my knowledge. I understand the importance of, and agree to notify, the dentist/hygienist of any changes at any subsequent appointment.

XSignature: _____ Date: _____

SKINNERDENTAL

HEALTHY SMILES TO LAST A LIFETIME

CONSENT TO PROCEED

I authorize Dr. Skinner, DDS and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rally, permanent numbness. I understand that occasionally needless break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possible quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cares, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription dugs that are currently being taken or that have been taken in the past. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all reasonable medical/dental risks, including the substantial and significant risk of serious harm, if any, which may be associated with any phase of standard dental preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name: _____

Signature: _____ Date: _____

(Patient, legal guardian or authorized agent of patient)

Witness: _____ Date: _____

SKINNER DENTAL
HEALTHY SMILES TO LAST A LIFETIME

ACKNOWLEDGEMENT OF RECEIPT OF OFFICE PRIVACY POLICIES

You may refuse to sign this acknowledgement.

I, _____, have read a copy of the Privacy Policies established for this office.

_____

Name (Please PRINT legibly)

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)