

# WELCOME TO OUR OFFICE!

Name: \_\_\_\_\_ By what name would you like to be called? \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phones: Home \_\_\_\_\_ Work \_\_\_\_\_ Ext \_\_\_\_\_

Cell \_\_\_\_\_ Email \_\_\_\_\_

SSN \_\_\_\_\_ Birthdate \_\_\_\_\_ TDL # \_\_\_\_\_

Has someone in your family been treated in our office?  Yes  No Married?  Yes  No Spouses name \_\_\_\_\_

Children? names and ages: \_\_\_\_\_

What do you like to do in your spare time? \_\_\_\_\_

Who referred you, or how did you hear about us? \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation/Position \_\_\_\_\_

Dental Insurance Carrier \_\_\_\_\_ Group # \_\_\_\_\_ Phone # \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

## HEALTH QUESTIONNAIRE

Who is your medical doctor(s) \_\_\_\_\_ Phone # \_\_\_\_\_

Are you under care for any medical condition?  Yes  No Describe \_\_\_\_\_

Medications?  Yes  No Name, dosage: \_\_\_\_\_

Allergies? \_\_\_\_\_ Do you smoke or use tobacco?  Yes  No

History of: (circle all that apply) : Heart disease, high blood pressure, diabetes, cancer, kidney, liver, or lung disease.

Excessive bleeding, artificial valves or joints, hepatitis, HIV or AIDS

Explanation for above, or other disease: \_\_\_\_\_

## DENTAL QUESTIONS

Do you have a specific concern or pain you need addressed? \_\_\_\_\_

What have you liked about previous dental offices or visits? \_\_\_\_\_

What have you not liked? \_\_\_\_\_

If you could easily improve your smile, would you be interested?  Yes  No

## PAYMENTS, INSURANCE AND AUTHORIZATIONS

The fees we charge are based on the time, skill, and judgement it takes to complete a procedure. We expect to produce exceptionally fine dentistry and most insurance companies pay for mediocrity; you will be responsible for any balance insurance does not pay within ninety days. If the cost of treatment is a concern of yours, financing options are available and should be agreed to prior to the appointment for treatment.

I authorize Dr. Scaff and his staff to administer medications and perform treatments as may be necessary for proper dental care. I understand I can ask questions on the treatments recommended and have the option to have no treatment, and realize risks are involved in each, including infection and loss of teeth. The information on this page is correct to my knowledge. I authorize payment of insurance claims to Dr. Scaff if assignment of benefits is chosen. I understand I am responsible for ALL the cost of my dental treatment, not the insurance company or our office.

X \_\_\_\_\_ Date \_\_\_\_\_