



# VAN ALSTYNE DENTAL

## Welcome to Our Practice!

We are committed to providing exceptional dental care to our patients in a compassionate, professional environment. The following information is provided to introduce you to our practice philosophy and policies.

### *Appointments*

Appointments are scheduled so we can provide the most efficient care in a relaxed setting. We make every effort to honor time commitments and we appreciate patients extending us the same courtesy. Patients are reminded of their appointments 2-3 days in advance by email, text, or phone. Patients are kindly asked to confirm their appointment at least 48 hours prior to their appointment through the reminder method employed.

### *Urgent Care After Hours*

We accommodate patients of record who experience dental emergencies after hours. A patient of record is one who has been seen and treated in the office during the past 18 months. If you are a patient of record and have a dental emergency, you can call the office for information on how to contact us. ***An after hours fee may be charged.***

### *Children and Adolescents*

We are happy to start seeing children at the age of three. Parents are welcome to accompany their children in the operatories. We require that parents remain in the office with children under the age of 18 for the entire appointment. Failure to comply may result in the appointment being rescheduled.

### *Payments and Insurance*

Payment for treatment is due and payable the day services are rendered. It is our goal, however, to assist all of our patients in obtaining the dental treatment they deserve. As a result, we offer several payment options, including cash, check, credit card, and third party financing. For patients with dental insurance, we will file the appropriate claim forms.

## **Cancellations and Missed Appointments**

We require 48 hours advance notice of a cancellation. Patients who do not provide 48 hours notice of a cancellation or who do not present for a scheduled appointment may be charged a fee of \$25. **I have read the Cancellation and Missed Appointment Policy. I understand and agree to this Policy.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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### **Patient Information**

Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Mobile #: \_\_\_\_\_

Email: \_\_\_\_\_

Sex: M / F Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS#: \_\_\_\_\_

Family Status (circle): Single Married Divorced Child Spouse's Name: \_\_\_\_\_

How did you first hear about our office? (circle one):

Another Patient

Another Dental Office

Brochure/Flyer

Online Search

Facebook

Work

School

Insurance Website

Sign - Drive by

Walk in

Other: \_\_\_\_\_

Whom may we thank for referring you to our practice? \_\_\_\_\_

### **Insurance Information (Primary) / Responsible Party**

Name of Insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Insured Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Employer: \_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_ Insurance Co Phone #: \_\_\_\_\_

Claims Address: \_\_\_\_\_

Group #: \_\_\_\_\_ ID #: \_\_\_\_\_

### **Insurance Information (Secondary)**

Name of Insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Insured Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Employer: \_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_ Insurance Co Phone #: \_\_\_\_\_

Claims Address: \_\_\_\_\_

Group #: \_\_\_\_\_ ID #: \_\_\_\_\_



# VAN ALSTYNE

## DENTAL

### Medical History

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. Date of last physical exam: \_\_\_\_\_ Physician's Name: \_\_\_\_\_  
Physician's Phone#: \_\_\_\_\_

2. Have you ever had any excessive bleeding requiring special treatment? Yes No

3. **Women:** Are you pregnant/trying to get pregnant/breast feeding? Yes No

4. Are you allergic to or have you had an allergic reaction to any of the following (please circle if yes):

Local Anesthetic      Penicillin      Codeine      Other Antibiotic: \_\_\_\_\_  
Latex      Acrylic      Metals      Other: \_\_\_\_\_

5. Please list other medications you are taking: \_\_\_\_\_ Pre-Med needed YES or NO

6. Date of last dental exam: \_\_\_\_\_ Date of last dental x-rays: \_\_\_\_\_

### **Have you ever had any of the following?**

|                   |        |                      |        |                   |        |
|-------------------|--------|----------------------|--------|-------------------|--------|
| Blood Thinner     | Yes No | Currently Pregnant   | Yes No | Due Date:         | _____  |
| Chest Pains       | Yes No | Shortness of Breath  | Yes No | Hives/Skin Rashes | Yes No |
| Heart Failure     | Yes No | Ulcers               | Yes No | Alcoholism        | Yes No |
| Heart Disease     | Yes No | Mental Health Issues | Yes No | Herpes            | Yes No |
| Heart Attack      | Yes No | Emphysema            | Yes No | Glaucoma          | Yes No |
| Heart Problems    | Yes No | Fainting/Dizziness   | Yes No | Pacemaker         | Yes No |
| Eating Disorder   | Yes No | Arthritis            | Yes No | Heart Surgery     | Yes No |
| Epilepsy/Seizures | Yes No | Liver Disease        | Yes No | Persistent Cough  | Yes No |
| Hypertension      | Yes No | Tuberculosis         | Yes No | Birth Defects     | Yes No |
| Heart Murmur      | Yes No | Asthma               | Yes No | HIV+, AIDS, ARC   | Yes No |
| Rheumatic Fever   | Yes No | Hepatitis A/B        | Yes No | Hay Fever         | Yes No |
| Psychiatric TX    | Yes No | Hepatitis C/D        | Yes No | Tobacco Products  | Yes No |
| Jaundice          | Yes No | Artificial Joints    | Yes No | Kidney Trouble    | Yes No |
| Thyroid Disease   | Yes No | Stroke               | Yes No | Diabetes          | Yes No |
| Anemia            | Yes No | Drug Addiction       | Yes No | Cancer            | Yes No |
| MVP               | Yes No | Sinus Trouble        | Yes No | Other             | _____  |

**I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_