PATIENT INFORMATION

In an effort to get to know you better, please fill in the following elective information.

Name: _____

Birthplace: _____

Where you grew up: _____

Where you have lived as an adult: _____

Marital Status: _____

Children, Ages: _____

Educational background: _____

Vocation: _____

Hobbies: _____

Special interests or activities:

_____

_____

Anything special you would like us to know:

_____

_____

Comments or Questions:

_____

_____

_____

_____

_____

PERSONAL INFORMATION

Date: _____

How did you find us? ___Yellow Pages ___ Website ___ Friend ___ Other _____

First Name: _____ Last Name: _____ Preferred Name: _____

Address: _____

City: _____ State/Prov.: _____ Zip Code: _____

Birth Date: _____ Drivers Licenses #: _____ SS#/SIN: _____

Home #: _____ Work #: _____ Cell #: _____

Male ___ Female ___ Minor ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated ___

Employer: _____ Occupation: _____

In the event of an emergency, who should we contact?

Name: _____ Relationship: _____

Work #: _____ Home #: _____ Cell #: _____

RESPONSIBLE PARTY

Who is responsible for the account?

Name: _____ Relationship to patient: _____ Birth Date: _____

SS#/SIN: _____ Address: _____

City: _____ State/Prov.: _____ Zip Code: _____

Employer: _____ Occupation: _____

Work #: _____ Home #: _____ Cell #: _____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION:

Name of Insured: _____ Insured Birth Date: _____

Insured SS#/SIN: _____ Employer: _____

Relationship: ___Self ___ Spouse ___Child ___Other

Insurance Company: _____

Address: _____ City: _____ State/Prov: ____

SECONDARY INSURANCE INFORMATION:

Name of Insured: _____ Insured Birth Date: _____

Insured SS#/SIN: _____ Employer: _____

Relationship: ___ Self ___ Spouse ___ Child ___ Other

Insurance Company: _____

Address: _____ City: _____ State/Prov: ____

AUTHORIZATION & RELEASE

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners.
I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____

Signature of patient or parent/guardian if minor Date

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment.
Please check the option which you prefer to make at each appointment.

___ Cash

___ Personal Check

___ Credit Card: ___ Visa ___ Master Card ___ American Express ___Discover

___ I wish to discuss the dental office's policy.

OFFICE USE ONLY:

_____

_____

_____

DENTAL HISTORY

How long has it been since last cleaning or exam?	___ Yes ___ No
Do your gums bleed when you brush or floss?	___ Yes ___ No
Are your teeth sensitive to hot or cold?	___ Yes ___ No
Are your teeth sensitive to sweet or sour?	___ Yes ___ No
Do you feel pain to any teeth?	___ Yes ___ No
Do you have any sores or lumps in or near your mouth?	___ Yes ___ No
Do you clench or grind your teeth?	___ Yes ___ No
Have you ever had any orthodontic treatment?	___ Yes ___ No
Do you like your smile?	___ Yes ___ No

Do you have, or have you had, any of the following?

AIDS/HIV Positive	___Yes ___ No	Fainting Spells/Dizziness	___ Yes ___ No	Parathyroid Disease	___ Yes ___ No
Alzheimer's Disease	___ Yes ___ No	Frequent Cough	___ Yes ___ No	Psychiatric Care	___ Yes ___ No
Anaphylaxis	___ Yes ___ No	Frequent Diarrhea	___ Yes ___ No	Radiation Treatments	___ Yes ___ No
Anemia	___ Yes ___ No	Frequent Headaches	___ Yes ___ No	Recent Weight Loss	___ Yes ___ No
Angina	___ Yes ___ No	Genital Herpes	___ Yes ___ No	Renal Dialysis	___ Yes ___ No
Arthritis/Gout	___ Yes ___ No	Glaucoma	___ Yes ___ No	Rheumatism	___ Yes ___ No
Artificial Heart Valve	___ Yes ___ No	Hay Fever	___ Yes ___ No	Scarlet Fever	___ Yes ___ No
Artificial Joint	___ Yes ___ No	Heart Attack/Failure	___ Yes ___ No	Shingles	___ Yes ___ No
Asthma	___ Yes ___ No	Heart Murmur	___ Yes ___ No	Sickle Cell Diseases	___ Yes ___ No
Blood Disease	___ Yes ___ No	Heart Pace Maker	___ Yes ___ No	Sinus Trouble	___ Yes ___ No
Blood Transfusion	___ Yes ___ No	Heart Trouble/Disease	___ Yes ___ No	Spinal Bifida	___ Yes ___ No
Breathing Problems	___ Yes ___ No	Hemophilia	___ Yes ___ No	Stomach/Intestinal Disease	___ Yes ___ No
Cancer	___Yes ___ No	Hepatitis A	___ Yes ___ No	Stroke	___Yes ___ No
Chemotherapy	___ Yes ___ No	Hepatitis B/C	___ Yes ___ No	Swelling of Limbs	___ Yes ___ No
Chest Pains	___ Yes ___ No	Herpes	___ Yes ___ No	Thyroid Disease	___ Yes ___No
Cold Sores/Fever Blisters	___ Yes ___ No	High Blood Pressure	___ Yes ___ No	Tonsillitis	___ Yes ___ No
Congenital Heart Disorder	___ Yes ___ No	Hives or Rash	___ Yes ___ No	Tuberculosis	___ Yes ___ No
Convulsions	___ Yes ___ No	Hypoglycemia	___ Yes ___ No	Tumors or Growths	___ Yes ___ No
Cortisone Medicine	___ Yes ___ No	Irregular Heartbeat	___ Yes ___ No	Ulcers	___ Yes ___ No
Diabetes	___ Yes ___ No	Kidney Problems	___ Yes ___ No	Venereal Disease	___ Yes ___ No
Drug Addiction	___ Yes ___ No	Leukemia	___ Yes ___ No	Yellow Jaundice	___ Yes ___ No
Easily Winded	___ Yes ___ No	Liver Disease	___ Yes ___ No		
Emphysema	___ Yes ___ No	Low Blood Pressure	___ Yes ___ No		
Epilepsy/Seizures	___ Yes ___ No	Lung Disease	___ Yes ___ No		
Excessive Bleeding	___ Yes ___ No	Mitral Valve Prolapse	___ Yes ___ No		
Excessive Thirst	___ Yes ___ No	Pain in Jaw Joints	___ Yes ___ No		

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE

HEALTH HISTORY

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ___ Yes ___ No If yes, please explain:

_____

Have you ever been hospitalized or had a major operation? ___ Yes ___ No If yes, please explain:

_____

Have you ever had a serious head or neck injury? ___ Yes ___ No If yes, please explain:

_____

Are you taking any medications, pills, or drugs? ___ Yes ___ No If yes, please explain:

_____

_____

Do you take, or have you taken, Phen-Fen or Redux? ___ Yes ___ No If yes, when: _____

Are you on a special diet? ___ Yes ___ No

Do you use tobacco? ___ Yes ___ No

Do you use controlled substances? ___ Yes ___ No

Women: Are you:

Pregnant/Trying to get pregnant ___Yes ___ No Taking oral contraceptives? ___ Yes ___ No

Nursing ? ___ Yes ___ No

Are you allergic to any of the following?

___Aspirin ___ Penicillin ___ Codeine ___ Sulfa ___ Acrylic ___Metal ___Latex

___ Local Anesthetics ___ Other If yes, please explain: _____

Dr. Teri Foy Sandlin
FAMILY, COSMETIC & IMPLANT DENTISTRY

OFFICE POLICY

DENTAL INSURANCE

We believe in the importance of quality dental care and strive to provide the best dental treatment possible. Also, we understand the financial limitation that influences your choice of care.

We work with most insurance companies as a courtesy and always try to maximize your coverage through meticulous detailing of procedures and interaction with your insurer. We even fill out your claim forms and we're available to answer any questions we can.

Please remember, however, that **you are responsible for the estimated portion of your treatment, not covered by insurance, the day your service is rendered**. We, too, must balance our finances. If you qualify, we'll work with you to devise a method of payment that works for both of us. We also accept most major credit cards. Please be advised that we allow insurance 3-4 weeks to respond. If your insurance has not responded with in that time, you are responsible for your balance. **Please pay these balances promptly according to statement due date to avoid collection cost**.

APPOINTMENTS

Our appointments are scheduled to respect your time. We reserve a specific time for your care and we make every effort to see you at that appointed time. We appreciate your promptness and consideration in not changing your scheduled time. **However, a verbal confirmation is required 24 hours before the time of your appointment. Your appointment will be cancelled if not confirmed. If you need to change an appointment, a 48 hour notice is expected. There is a $50.00 charge for less than 48 hour notice.**

We hope that you find this information useful. Rest assured that we are here to help make quality dental care obtainable for all. We look forward to working with you to achieve excellent dental health.

INFORMATION CHANGES

It is agreed that Dr. Sandlin will make every effort to process refunds within five (5) business days from the date the request is made**. Please keep your personal information up to date, as a verifiable address must be available in order to mail payment.** All credits remaining on our books for more than two years will be deleted.

FINANCE CHARGE: **If I do not pay the entire new balance within 25 days of the monthly billing date a finance charge may be added to the account for the current monthly billing period. The finance charge will be a periodic rate of 1.5% per month (annual percentage rate of 18% applied to the previous month's ending balance). In the case of default of payment I promise to pay said fee including the cost of collections (33.33%), attorney fees, and court costs incurred to collect on this account, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama, or any other state.**

8161 A Seaton Place • Montgomery, AL 36116 • Telephone (334)279-6488 Fax (334)279-6487

Dr. Teri Foy Sandlin
FAMILY, COSMETIC & IMPLANT DENTISTRY

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: _____

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