feather touch dental care

Welcome to Feathertouch!

About You…

Date_____ File #_____

Patient Name _____ Name you prefer to be called _____

Last First MI

Birthdate_____ age_____ ❒ Male ❒ Female SS# _____

Mailing Address_____

City_____ State_____ Zip_____

Home Phone_____Work_____ Cell_____

Email_____

How did you hear about our office? _____

Employer_____ Occupation_____

Employer's Address_____

City_____ State_____ Zip_____

❒ Minor ❒ Single ❒ Married ❒ Divorced ❒ Separated ❒ Partner Spouse's Name _____

Do you have children? ❒ Yes ❒ No How Many_____

Account Information…

Person Responsible for Account

Name_____Relationship_____

Billing Address_____

City_____State_____Zip_____SS#_____Driver's License #_____

Work Phone _____ Payment Method ▫ Cash ▫ Check ▫ Card Credit Card #_____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid for by my insurance company(if offered at this office).

Initial_____

Insurance Information…

Primary Dental Insurance

Co. Name _____ Address _____

City _____ State _____ Zip _____ Phone _____

Insured's SS # _____ Group # _____

Insured's Name _____ Relationship _____

Birthdate _____ Insured's Employer _____

As a courtesy to our patients, we will be happy to file your insurance for you. At time of treatment, you'll be responsible for paying your deductible and/or co-payment. Insurance coverage is estimated — your actual coverage may be less. You, the patient, are responsible for all amounts not covered by your insurance carrier, regardless of reason. Any balance not paid by your insurance company within 45 days is due and is to be paid by you.

Initial _____

In Case of Emergency…

Who should we contact? _____

Home Phone _____ **Work Phone** _____

Who is your Medical Doctor? _____ **MD's Phone** _____

Dental Information…

Reason for today's visit ❒ Exam ❒ Emergency ❒ Consultation

Are you in pain? ❒ No ❒ Yes How long? _____

Please list any medications: _____

_____

Do you require pre-medication? ❒ Yes ❒ No ❒ Don't Know

Previous Dentist _____ Phone # _____

Last Dental Exam _____ Last Dental X-Rays _____

Times a day you brush? _____ Times a week you floss? _____

What type of tooth brush bristles do you use? ❒ Soft ❒ Medium ❒ Hard

How would you rate your smile? 1 2 3 4 5 6 7 8 9 10

Dental Information...

	YES	NO
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Do you wear dentures?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty in chewing your food?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Do you avoid brushing any part of your mouth because of pain?	☐	☐
Do your gums bleed when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you ever noticed slow-healing sores in or about your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?	☐	☐
Cold foods or liquids?	☐	☐
Sours?	☐	☐
Sweets?	☐	☐
Do you take fluoride supplements?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Do you prefer to save your teeth?	☐	☐
Do you want complete dental care?	☐	☐
Does your jaw make noise so that it bothers you or others?	☐	☐
Do you clench or grind your jaws frequently?	☐	☐
Do your jaws ever feel tired?	☐	☐
Does your jaw get stuck so that you can't open freely?	☐	☐
Does it hurt when you chew or open wide to take a bite?	☐	☐
Do you have earaches or pain in front of the ears?	☐	☐
Do you have any jaw symptoms or headaches upon awaking in the morning?	☐	☐
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	☐	☐
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	☐	☐
Are you unable to open your mouth as far as you want?	☐	☐
Are you aware of an uncomfortable bite?	☐	☐
Have you had a blow to the jaw (trauma)?	☐	☐
Are you a habitual gum chewer or pipe smoker?	☐	☐

Medical Health History

	YES	NO
Do you have, or have you had, any of the following?		
Heart Problems		
Chest pain	☐	☐
Shortness of breath	☐	☐
Blood pressure problem High/Low	☐	☐
Congenital heart defect	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Rheumatic fever	☐	☐
Pacemaker	☐	☐
Artificial heart valve	☐	☐
Mitral valve prolapse	☐	☐
Blood Problems		
Are you taking Coumadin/Warfarin?	☐	☐
Easy bruising	☐	☐
Frequent nosebleeds	☐	☐
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Ever require blood transfusion?	☐	☐
Allergy Problems		
Hay fever	☐	☐
Sinus problems	☐	☐
Skin rashes	☐	☐
Taking allergy medication	☐	☐
Asthma	☐	☐
Difficulty breathing	☐	☐
Intestinal Problems		
Ulcers	☐	☐
Weight gain or loss	☐	☐
Special diet	☐	☐
Constipation/Diarrhea	☐	☐
Kidney or bladder problems	☐	☐
Bone or Joint Problems		
Arthritis	☐	☐
Back or neck pain	☐	☐
Joint replacement	☐	☐
Sleep Apnea	☐	☐
Do you snore?	☐	☐
Do you feel tired frequently throughout the day?	☐	☐
Has anyone heard you gasp for air while asleep?	☐	☐
Fainting Spells, Epilepsy, or Seizures	☐	☐
Stroke	☐	☐
Frequent or Severe Headaches	☐	☐
Thyroid Problems	☐	☐
Chemo/Radiation Therapy?	☐	☐

	YES	NO
Psychiatric Problems	☐	☐
Persistent Cough or Swollen Glands	☐	☐
Premedication required by physician	☐	☐
Cancer/Tumor	☐	☐
Diabetes/Hypoglycemia	☐	☐
Urinate more than 6 times per day	☐	☐
Thirsty or mouth is dry much of the time	☐	☐
Family history of diabetes	☐	☐
Tuberculosis or other respiratory disease	☐	☐
Shingles	☐	☐
Do you drink alcohol?	☐	☐
If so, how much?		
Do you smoke?	☐	☐
If so, how much?		
Emphysema	☐	☐
Scarlet Fever	☐	☐
Hepatitis, jaundice, or liver trouble	☐	☐
Herpes or other STD	☐	☐
HIV-positive/AIDS/ARC	☐	☐
Venereal Disease	☐	☐
Glaucoma	☐	☐
Do you wear contact lenses?	☐	☐
History of head injury?	☐	☐
Do you wear contact lenses?	☐	☐
History of back problems?	☐	☐
Epilepsy or other neurological disease?	☐	☐
History of alcohol or drug abuse?	☐	☐
Do you have any disease, condition, or problem not listed previously that you feel we should know about?	☐	☐
If so, please describe:		

	YES	NO
Are you allergic, or have you reacted adversely, to any of the following?		
Local anesthetics ("Novocaine")	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedative, or sleeping pills	☐	☐
Aspirin, Acetaminophen or Ibuprofen	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber dam	☐	☐
Other:		
During the past 12 months, have you taken any of the following?		
Antibiotics or Sulfa drugs	☐	☐
Muscle relaxers	☐	☐
Anticoagulants (Coumadin)	☐	☐
High blood pressure medicine	☐	☐
Tranquilizers	☐	☐
Insulin, Orinase, or similar drug	☐	☐
Stimulants	☐	☐
Aspirin or any other painkillers	☐	☐
Digitalis or drugs for heart trouble	☐	☐
Nitroglycerin	☐	☐
Nerve pills	☐	☐
Cortisone (steroids)	☐	☐
Natural remedies	☐	☐
Nonprescription drug/supplements	☐	☐
Other:		
Women		
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant?	☐	☐
If so, expected delivery date:		
Are you nursing?	☐	☐
Have you reached menopause?	☐	☐
If so, do you have any symptoms?	☐	☐
	☐	☐

We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If an account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

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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Appointment Cancellation Protocol

We strive to render excellent dental care to our patients. In an attempt to be consistent with this, we have an Appointment Cancellation Protocol that allows us to reserve appointments for all patients. When an appointment is reserved, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

We require that you give our office 48 hours notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a broken appointment. A fee of $50.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. If a patient is more than 15 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $50.00 cancellation fee will be charged. If you have any questions regarding this protocol, please let our team know and we will be glad to clarify any questions you have.

I have read and understand the Appointment Cancellation Policy of the practice.
I understand and agree that such terms may be amended from time-to-time by the practice.

Signature _____

Name printed _____

Date _____

Witness _____