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 _____ _____

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** _____

Authorized Family member...

I _____, direct my health care and medical services providers and payers to disclose and release my protected health information to:

Name _____. Relationship to patient _____

Contact information (Phone number/email): _____

Initial _____

DENTAL HISTORY

Patient Name _____ Nickname _____ Age _____

Referred by _____ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist _____ How long have you been a patient? _____ Months/Years

Date of most recent dental exam ____/____/____ Date of most recent x-rays ___/____/____

Date of most recent treatment (other than a cleaning) ____/____/____

I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you ever had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	☐	☐
6. Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma?	☐	☐
GUM AND BONE	**YES**	**NO**
7. Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing?	☐	☐
8. Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth?	☐	☐
9. Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums?	☐	☐
10. Is there anyone with a history of periodontal disease in your family?	☐	☐
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth?	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing?	☐	☐
13. Have you experienced a burning, painful sensation, or metallic taste in your mouth?	☐	☐
TOOTH STRUCTURE	**YES**	**NO**
14. Have you had any cavities within the past 3 years?	☐	☐
15. Does the amount of saliva in your mouth seem too little, not enough, or do you have difficulty swallowing or chewing any food?	☐	☐
16. Do you feel or notice any holes (i.e., pitting, craters) on the biting surface of your teeth?	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18. Do you have grooves or notches on your teeth near the gum line?	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20. Do you frequently get food caught between any teeth?	☐	☐
BITE AND JAW JOINT	**YES**	**NO**
21. Does your jaw joint ever have pain, sounds (clicking, crackling, or popping), or experience limited opening or locking?	☐	☐
22. Do you feel like you need to pull your lower jaw back, or feel that it is being pushed back when you try to bite your back teeth together?	☐	☐
23. Do you avoid or have difficulty chewing gum, raw carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26. Are your teeth developing spaces or becoming more loose?	☐	☐
27. Do you have more than one bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together better?	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30. Do you clench or grind your teeth together in the daytime / nighttime or ever make them sore?	☐	☐
31. Do you have any problems with sleep (i.e., restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32. Do you wear or have you ever worn a bite appliance?	☐	☐
SMILE CHARACTERISTICS	**YES**	**NO**
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (color, spaces, size, shape, display)?	☐	☐
34. Have you ever bleached (whitened) your teeth?	☐	☐
35. Have you felt uncomfortable or self-conscious about the appearance of your teeth?	☐	☐
36. Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD: YES NO

1. hospitalization for illness or injury _____
2. an allergic or bad reaction to any of the following:
   - ☐ aspirin, ibuprofen, acetaminophen, codeine _____
   - ☐ penicillin _____
   - ☐ erythromycin _____
   - ☐ tetracycline _____
   - ☐ sulfa _____
   - ☐ local anesthetic _____
   - ☐ fluoride _____
   - ☐ chlorhexidine (CHX) _____
   - ☐ Iodine _____
   - ☐ metals (nickel, gold, silver, _____)
   - ☐ latex _____
   - ☐ nuts _____
   - ☐ fruit _____
   - ☐ milk _____
   - ☐ red dye _____
   - ☐ other _____
3. heart problems, or cardiac stent within the last six months _____
4. history of infective endocarditis _____
5. artificial heart valve, repaired heart defect (PFO) _____
6. pacemaker or implantable defibrillator _____
7. orthopedic or soft tissue implant (e.g., joint replacement, breast implant) _____
8. heart murmur, rheumatic or scarlet fever _____
9. high or low blood pressure _____
10. a stroke (taking blood thinners) _____
11. anemia or other blood disorder _____
12. prolonged bleeding due to a slight cut (or INR > 3.5) _____
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____
14. chronic ear infections, tuberculosis, measles, chicken pox _____
15. breathing problems (e.g., asthma, nasal breathing, stuffy nose, sinus congestion)
16. sleep problems (e.g., sleep apnea, snoring, insomnia, restless sleep, bedwetting) _____
17. kidney disease _____
18. liver disease or jaundice _____
19. vertigo (e.g., "the room is spinning") _____
20. thyroid, parathyroid disease, or calcium deficiency _____
21. hormone deficiency or imbalance (e.g., polycystic ovarian syndrome) _____
22. high cholesterol or taking statin drugs _____
23. diabetes (HbA1c = _____) _____
24. stomach or duodenal ulcer _____
25. digestive or eating disorders (e.g., gastric reflux, bulimia, anorexia, celiac disease, Crohn's disease, or any inflammatory bowel disease) _____
26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g., bisphosphonates) _____
27. arthritis or gout _____
28. autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma) _____
29. glaucoma _____
30. contact lenses _____
31. head or neck injuries _____
32. epilepsy, convulsions (seizures) _____
33. neurologic disorders (e.g., Alzheimer's disease, dementia, prion disease)
34. viral infections (e.g., cold sores) bacterial infections (e.g., Lyme disease) _____
35. any lumps or swelling in the mouth _____
36. hives, skin rash, hay fever _____
37. STI/STD/HPV _____
38. hepatitis (type ____) _____
39. HIV/AIDS _____
40. tumor, abnormal growth _____
41. radiation therapy _____
42. chemotherapy, immunosuppressive medication _____
43. difficulties with stress management _____
44. psychiatric treatment, antidepressants, mood stabilizing medications
45. concentration problems or ADD/ADHD _____
46. alcohol/recreational drug use _____

ARE YOU:

47. presently being treated for any other illness _____
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____
49. taking medication for weight management _____
50. taking dietary supplements, vitamins, and/or probiotics _____
51. often exhausted or fatigued _____
52. experiencing frequent headaches or chronic pain _____
53. a smoker, smoked previously or other (e.g., smokeless tobacco, vaping, e-cigarettes, and cannabis) _____
54. considered a touchy/sensitive person _____
55. often unhappy or depressed _____
56. taking birth control pills _____
57. currently pregnant _____
58. diagnosed with a prostate disorder _____

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

List all medications, supplements, vitamins, and/or probiotics taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ **(1-6)**

Financial Policy

Thank you for choosing us as your dental care provider. Please read carefully and sign to acknowledge understanding and agreement. We are committed to providing you with the best dental care available.

- You can choose from: **CASH, CHECK, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS.**
- We offer a **CARE CREDIT** payment plan option- ask us for detailed information.
- **Payment is due in full on the day that treatment is provided. If your bill is being settled by someone else, payment must be obtained at the time of check out.**

PATIENTS WITH INSURANCE

- Please provide our office with a copy of the front and back of your dental insurance card.
- As a courtesy, we will file your dental claims with your provided insurance and attempt to answer any questions we can about your insurance, when possible. Please understand that we cannot speak on their behalf. Your insurance contract is an agreement between you, your employer, and your insurance carrier. If the event occurs that your insurance company has not paid (on your behalf), you will be responsible for all balances.

PATIENTS WITHOUT INSURANCE

- For those patients without insurance coverage, you will be responsible for full payment on the day of treatment. You will be given an estimate and will be able to discuss financial options with our treatment coordinator.

CANCELLATION/ NO SHOW/ AFTER HOURS POLICY

Our office requires **2 business days'** notice to cancel your appointment in the case of a conflict or emergency. Please be aware of our current office business hours, as they are not in line with banking hours. Our office reserves the right to charge $**125.00**, for those not giving adequate advance notice.

COLLECTIONS

- A $35.00 charge will be added to your account for any returned checks. You are responsible for all financial costs of collecting or attempting to collect any debt owed to your account. This includes all attorneys' fees, interest, and late fees.
- We reserve the right to send your account to collections, should you fail to pay for the services you receive at our office in a timely manner.

Signature: _____

Date: _____