PROSPER FAMILY DENTISTRY

Jill H. Sentlingar DDS • Cara Kessler DDS

New Patient Acquaintance Form

Name (First, Middle, Last) – Please write full legal name, must match I.D.		Home Phone ( )	Work/Cell Phone ( )	
Address		City	State	Zip
Occupation	Employer	Email address	Date of Birth	Sex
SSN:	Emergency Contact:	Relationship:	Phone:	
Spouse's name	Spouse's phone number (_____) -	How did you find out about our office?		
If you are completing this form for another person, what is your relationship to that person?				
Your Name:		Relationship:		

Insurance Information:

Name of insured person	SSN _____-_____-_____	Date of birth ___/___/_____
Employer's name	Employer's address	
Insurance company	Phone number	Group number

_____
(Initials)

CANCELLATION POLICY: As a courtesy to other patients, all cancellations must be made by 10:00am 2 business days preceding any scheduled appointments. If cancellations occur after this time, your account may be charged a cancellation fee. These fees may vary. If you do not show for your scheduled appointment, your account will be charged a "no-show" fee.

Medical Information:

	Yes	No
Are you now under the care of a physician? Physician name: Phone number ( )	☐	☐
Has there been any change in your health in the last year? If yes, what condition is being treated?	☐	☐
Do you have any food allergies? If yes, please list:	☐	☐
Are you taking any prescription or over-the-counter medications? If yes, please list all, including vitamins, natural or herbal preparations and/or diet supplements in the adjacent space.	☐	☐
Have you had a serious illness, operation or been hospitalized in the past 5 years? If yes, what was the illness or problem?	☐	☐
Have you ever had a reaction to latex?	☐	☐
Have you ever had a reaction to metal or jewelry?	☐	☐
Have you ever had a reaction to any type of medication? If yes, please list:	☐	☐

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	Yes	No
Do you wear contact lenses?	☐	☐
Are you taking, or have you taken, any diet drugs such as Pondimin, Redux, or Phen-Fen?	☐	☐
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease?	☐	☐
Since 2001 were you treated or are you presently scheduled to begin treatment with the IV bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Date treatment began:	☐	☐

	Yes	No
Do you use controlled substances (drugs)?	☐	☐
Do you use tobacco (smoking, snuff, chew)?	☐	☐
If so, how interested are you in stopping? *(Circle one)* VERY SOMEWHAT NOT INTERESTED		
Do you drink alcohol daily?	☐	☐
Have you had an orthopedic total joint replacement? Date: _____	☐	☐
WOMEN ONLY Are you: Pregnant? Number of weeks: _____	☐	☐
Taking birth control pills or hormone replacement?	☐	☐
Nursing?	☐	☐

Medical History:

Please mark your response to indicate if you have any of the following diseases or problems.

	Yes	No		Yes	No		Yes	No
Heart murmur	☐	☐	Anemia	☐	☐	Diabetes	☐	☐
Mitral valve prolapse	☐	☐	Blood transfusion	☐	☐	Eating disorder	☐	☐
Artificial heart valves	☐	☐	Hemophilia	☐	☐	Malnutrition	☐	☐
Rheumatic fever	☐	☐	AIDS or HIV infection	☐	☐	GI disease	☐	☐
Cardiovascular disease	☐	☐	Arthritis	☐	☐	Severe or rapid weight loss	☐	☐
Angina	☐	☐	Autoimmune disease	☐	☐	Acid reflux/heartburn	☐	☐
Arteriosclerosis	☐	☐	Rheumatoid arthritis	☐	☐	Ulcers	☐	☐
Congestive heart failure	☐	☐	Systemic lupus	☐	☐	Thyroid problems	☐	☐
Coronary artery disease	☐	☐	Asthma	☐	☐	Stroke	☐	☐
Damaged heart valves	☐	☐	Bronchitis	☐	☐	Glaucoma	☐	☐
Heart attack	☐	☐	Emphysema	☐	☐	Hepatitis or liver disease	☐	☐
Low blood pressure	☐	☐	Sinus trouble	☐	☐	Excessive urination	☐	☐
High blood pressure	☐	☐	Tuberculosis	☐	☐	Epilepsy	☐	☐
Congenital heart defects	☐	☐	Cancer/Chemotherapy	☐	☐	Fainting spells or seizures	☐	☐
Pacemaker	☐	☐	Radiation treatment	☐	☐	Neurological disorders	☐	☐
Rheumatic heart disease	☐	☐	Chest pain upon exertion	☐	☐	If yes, please specify:		
Abnormal bleeding	☐	☐	Chronic pain	☐	☐	Sleep disorder	☐	☐
Recurrent infection	☐	☐	Kidney problems	☐	☐	Mental health disorders	☐	☐
Night sweats	☐	☐	Osteoporosis	☐	☐	Please specify: _____		
Persistent swollen glands	☐	☐	Severe headaches	☐	☐	Sexually transmitted disease	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐

Please explain: _____

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical status to my treating doctor as soon as possible, and I agree to do so. I give permission to my treating doctor to obtain from my physician information regarding my medical history, if needed, to provide me the best treatment possible. I hereby authorize Dr. Sentlingar and the appropriate staff members to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate for my dental needs.

Patient Signature: _____ Date: _____

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Dental History:

When was the last time you saw a dentist?

What was done at that time?

What is the reason for your visit today?

	Yes	No		Yes	No
Have you ever been treated for periodontal disease?	☐	☐	Does dental treatment make you nervous?	☐	☐
Have you had orthodontic treatment (braces)?	☐	☐	Have you had an unpleasant dental experience?	☐	☐
How often do you brush your teeth?			What type of toothbrush do you use? *(circle one)* Soft Medium Hard Electric		
Do you use dental floss or tape?	☐	☐	How often?		
What other cleaning aids, devices or rinses do you use?					

Do you experience any of the following?	Yes	No		Yes	No
Bleeding or sore gums	☐	☐	Loose teeth	☐	☐
Bad breath/unpleasant taste	☐	☐	Sensitive to hot	☐	☐
Tingling or burning tongue or lips	☐	☐	Sensitive to cold	☐	☐
Swelling or lumps in mouth	☐	☐	Sensitive to sweets	☐	☐
Sores in mouth	☐	☐	Clicking or popping jaw	☐	☐
Food trapping between teeth	☐	☐	Frequent headaches	☐	☐
Trouble swallowing without water	☐	☐	Grinding or clenching	☐	☐

Smile Evaluation:

	Yes	No
Are you self-conscious when you smile in front of other people or in pictures?	☐	☐
Do you ever cover your smile with your hand?	☐	☐
Do you have old fillings or dental work that you don't like looking at?	☐	☐
Do you wish your teeth were whiter?	☐	☐
Do you dislike the shape of your teeth?	☐	☐
Do you have spaces between your teeth that you don't like?	☐	☐
Do you wish your teeth were straighter?	☐	☐
Are you unhappy with crowded or crooked teeth?	☐	☐

If you could wave a "magic wand" and change the appearance of your smile, how would you like it to look?

Please list any questions you may have about your mouth or oral health:

Sleep Evaluation

	Yes	No
Do you wake up feeling tired after a full night of sleep?	☐	☐
Do you snore?	☐	☐
Does your spouse snore?	☐	☐
Have you ever been diagnosed with sleep apnea?	☐	☐
If yes, are you currently wearing a sleep device?	☐	☐
If yes, are you happy with this treatment?	☐	☐

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Prosper Family Dentistry Office and Financial Policies

This is an outline of our office financial policies. We ask that you provide any/all insurance information to us upon arrival of your first visit with us. If the information is provided to us prior to this appt, we will make every attempt to verify coverage of benefits for you in advance. While we do our very best to outline your plan to you, it is ultimately your responsibility to know your insurance plan benefits and restrictions. Based upon the information given to us by your insurance plan, we will ask for co-payments accordingly. Please note that our dentists are not contracted with any insurance plan. We are an out of network provider office and your benefits may vary accordingly. We do collect an additional 10 % of the charges incurred above and beyond what your insurances quotes to our office. In many cases, the end result will result in a credit balance to the patient account. These credits will be reimbursed.

It is important to remember that your insurance policy is a contract between you and the insurance company. We will do everything possible to assist you in getting your claim paid: however, all charges incurred for your dental treatment are your sole financial responsibility. Your co-payments are an estimate only. The quotes given to our office by your insurance company are merely that. They are not a guarantee of payment to us. We ask that you pay your co-payment, deductible (if required), or any balances of prior visits at the time services are rendered. If you are unable to pay your estimated portion for that time, we ask that you make prior financial arrangements with our billing representative.

If you do not have dental insurance, by signing this statement you acknowledge that you understand that you are responsible for payment in full at the time services are rendered. If you have insurance, by signing this statement you acknowledge that your insurance company may pay less than the actual bill for services and that you are fully responsible for payment of your account. By signing this statement you agree to pay for all balances not paid by your insurance company and any legal fees incurred to enforce this statement. If a balance on any account is not paid within 30 days, you could be charged interest on that account until paid in full.

We do accept personal checks, cash payments and credit card payments. We also offer a 5% Cash Professional Courtesy for any treatment prepaid to us in full. We will file your insurance as a courtesy for you. In addition to this, we offer a 5% Senior Citizen Courtesy. A Credit Card Authorization form is also available to keep on file for your account balances. See Front desk staff for these forms.

I hereby authorize the release of any information relating to insurance claims and I authorize payment of my group benefits directly to Jill H. Sentlingar, DDS and Prosper Family Dentistry P.A. I agree to give Prosper Family Dentistry permission to contact me regarding appointments and/or treatment at the phone number listed above.

I certify that the information I have provided here is true and correct.

Adult/Guardian Signature: _____ **Date:** _____

Patient Name: _____ **Relationship:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____ _____

Signature Date

Employee Signature _____ _____ Individual refused to sign

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