**Patient Last Name:**

**First: Middle:**

How do you wish to be addressed? Date of Birth:

Address Parish

Zip Telephone (mobile) (work)

(home) Email

**Emergency Contact**

**Name**

**Telephone**

**\*\*Best Way to Receive Communication about an upcoming Appointment:**

**Cancellations and Missed Appointments**

The entire team here at Toothworx makes every effort to accommodate you and your busy schedule. If you are unable to keep an appointment, we ask that you kindly provide us with minimum of **two‐business days notice**. Our office does not except cancellation or changes in appointments after hours by voice mail; you **must** call during our normal business hours. This courtesy on your part will make it possible to give your appointment to another patient who needs to see the dentist or hygienist. If you must cancel with less notice or if you fail to attend a confirmed appointment, you will incur a **$100 fee** unless our team is able to fill your appointment time with another patient.

**AUTHORIZATION**

I consent to all diagnostic procedures and dental treatment performed by my dentist at Toothworx. I consent to the release of information concerning my (or my child’s) overall or dental health and recommended or rendered treatment to another dentist or physician for evaluation and/or consult. I agree to Toothworx submitting any claims for insurance benefits or pre-estimates on my behalf. I understand that my insurance benefits may pay less than the actual cost of services and that I am responsible for any remaining balance (copay) AT THE TIME OF SERVICE. If, for any reason, I will not be able to pay my copay at the time of service, I will talk to the Office Manager about a payment plan before committing to my appointment with the dentist or dental hygienist.

If after 30 days your account is still outstanding, we will follow up with a mailed statement and email or phone call. If after 60 days the account is still outstanding, finance charges will be applied to your account you will be responsible for these charges. After 90 days your account will be submitted to the Bermuda Credit Association for collection, with an additional **54%** surcharge added to the account to cover costs for collection. Unfortunately at this time you will also be dismissed from our practice.

**\*\*Signature of Patient** or Guardian(if patient is a minor)

**Date** (dd/mm/yyyy)

**Responsible Party of a Minor**

**Last Name**

**First Name Middle Name**

**Address** (if different)

**Parish Zip**

**Telephone** (home) (work)

(mobile) **Email**

**Insurance Information** - *Please present your insurance card*

|  |  |
| --- | --- |
| **Primary Insurance** | |
| **Name of Insurance Co** |  |
| **Policy Number** |  |
| **Certification Number** |  |
| **Relationship to Subscriber** | Self Spouse Child Other |
| **Employer Name** |  |
| **Employer Phone Number** |  |

|  |  |
| --- | --- |
| **Secondary Insurance** | |
| **Name of Insurance Co** |  |
| **Policy Number** |  |
| **Certification Number** |  |
| **Relationship to Subscriber** | Self Spouse Child Other |
| **Employer Name** |  |
| **Employer Phone Number** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Medical History** | | | |
| **Physician's Name** | | | |
| **Date of Last Annual Physical** | | | |
| **Are you pregnant?(women) If Yes, what is your due date?** | | | |
| **Have you had or do you have the following:** | Yes | No | Surgery Date/Associated Medications |
| **Acid Reflux** |  |  |  |
| **AIDS/HIV** |  |  |  |
| **Arthritis** |  |  |  |
| **Artificial Heart Valve** |  |  |  |
| **Artificial Joints** |  |  |  |
| **Asthma** |  |  |  |
| **Abnormal bleeding with surgery/operations** |  |  |  |
| **Blood Disease, clotting disorders** |  |  |  |
| **Cancer** |  |  |  |
| **Chemical Dependency** |  |  |  |
| **Chemotherapy** |  |  |  |
| **Circulatory Problems** |  |  |  |
| **Cortisone Treatment** |  |  |  |
| **Persistent Cough** |  |  |  |
| **Diabetes** |  |  |  |
| **Eating Disorder** |  |  |  |
| **Emphysema** |  |  |  |
| **Epilepsy** |  |  |  |
| **Fainting** |  |  |  |
| **Glaucoma** |  |  |  |
| **Headaches** |  |  |  |
| **Heart Problems** |  |  |  |
| **Hepatitis (include type)** |  |  |  |
| **High blood pressure** |  |  |  |
| **Low Blood Pressure** |  |  |  |
| **Any Immune deficiency** |  |  |  |
| **Kidney Disease/Kidney problems** |  |  |  |
| **Mitral Valve Prolapse** |  |  |  |
| **Osteoporosis/Osteopenia** |  |  |  |
| **Pacemaker** |  |  |  |
| **Radiation Treatment** |  |  |  |
| **Have you had or do you have the following:** | Yes | No | Surgery Date/Associated Medications |
| **Shortness of breath** |  |  |  |
| **Sinus Issues** |  |  |  |
| **Sickle Cell Anemia** |  |  |  |
| **Slow Wound Healing** |  |  |  |
| **Stroke** |  |  |  |
| **Thyroid Disease (hypo-/hyperthyroidism)** |  |  |  |
| **Tonsillitis** |  |  |  |
| **Do you wear contact lenses?** |  |  |  |
| **Do you drink alcohol?** |  |  |  |
| **Do you have any allergies? Please list** |  |  |  |
| If Yes explain | | | |
|
| **List any other medications not previously listed:** | | | |
|  | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Dental History** | | | |
| **Previous Dentist** | | | |
| **Date of Last Dental Visit** | | | |
| **Reason for Last Dental Visit** | | | |
| **Have you had or do you have the following:** | Yes | No | Currently Experiencing |
| **Bad Breath** |  |  |  |
| **Dry Mouth** |  |  |  |
| **Clench/Grind your Teeth** |  |  |  |
| **Bleeding gums** |  |  |  |
| **Frequent mouth ulcers** |  |  |  |
| **Head, neck, and/or jaw pain** |  |  |  |
| **Lip or cheek biting** |  |  |  |
| **Cigarette, pipe or cigar smoking (how much/day )** |  |  |  |
| **Loose permanent (adult) teeth** |  |  |  |
| **Mouth breathing** |  |  |  |
| **Orthodontic treatment (braces/Invisalign)** |  |  |  |
| **Periodontal Treatment** |  |  |  |
| **An Adverse reaction to local anesthetic** |  |  |  |
| If Yes explain | | | |
|
| **How often do you brush your teeth?** | | | |
| **How often do you clean between your teeth?** | | | |
| **What do you use to clean between your teeth?** | | | |
| **Have you ever had an adverse reaction to dental care?** | | | |
| If Yes explain | | | |

I have read the Medical and Dental History questions and answered to my best knowledge and ability.

Signature: Date:

Reviewed By: Date: