LANDMARK DENTAL GROUP
NEW PATIENT INFORMATION

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us- we will be happy to help.

Whom may we thank for referring you?_____

ABOUT YOU

Name:_____ I prefer to be called_____ ( ) Male ( ) Female
( ) Single ( ) Married ( ) Child Birth date ___/___/___ Age ____ S.S # _____
Home Address:_____ City _____ State _____ Zip _____
Home Phone ( )_____ Work ( ) _____ext_____ Cell ( ) _____
E-mail Address _____ Employer _____
Occupation _____ Employer's Address_____
Can you clearly understand/communicate the English language?_____

PERSON RESPONSIBLE FOR ACCOUNT

( ) Same as above
Name _____ Birth date ____/____/_____ Relation_____
Billing Address_____ City_____ State_____ Zip _____
Home Phone( )_____ Work ( )_____ S.S #_____

SPOUSE INFORMATION

( ) Same as above
Name_____ Birth date____/____/____
Employer_____Work Phone( )_____ EXT_____

DENTAL INSURANCE INFORMATION

Primary Insurance
Insurance Co. Name_____ Phone( )_____ Group/Policy#_____
Insured's Name_____Insured's Birth date ____/____/____ Relation_____
Insured's S.S#_____ Insured's Employer_____

Secondary Insurance
Insurance Co. Name_____ Phone( )_____ Group/Policy#_____
Insured's Name_____Insured's Birth date ____/____/____ Relation_____
Insured's S.S#_____ Insured's Employer_____

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MEDICAL HISTORY INFORMATION

Name of Physician_____Phone ( )_____

Do you have or have ever had any of the following? Please check those that apply

( ) Allergies/Hay Fever	( ) Diabetes	( ) Heart Surgery*	( ) Rheumatic Fever
( ) Anemia	( ) Epilepsy or Seizures	( ) Hepatitis	( ) Rheumatism
( ) Angina	( ) Excessive Thirst	( ) High Blood Pressure	( ) Sickle Cell Disease
( ) Arthritis	( ) Fainting or Dizziness	( ) HIV/AIDS	( ) Sinus Problems
( ) Artificial Joints*	( ) Fever Blisters/Cold Sores	( ) Kidney Problems	( ) Stroke
( ) Artificial Heart Valves*	( ) Frequent Cough	( ) Liver Problems	( ) Surgical Shunt*
( ) Asthma	( ) Glaucoma	( ) Mental Disorders	( ) Thyroid Problems
( ) Breathing Problems	( ) Heart Disorder*	( ) Mitral Valve Prolapse*	( ) Tuberculosis
( ) Cancer	( ) Heart Infection*	( ) Osteoporosis	( ) Ulcers
( ) Chemical Dependency	( ) Heart Murmur*	( ) Radiation Treatment	( ) Venereal Disease
( ) Chemotherapy	( ) Heart Pace Maker*	( ) Respiratory Problems	( ) Yellow Jaundice

* This condition may require antibiotic premedication for certain dental procedures

YES or No: please check the one that applies

( ) ( ) Do you have any health problems that were not listed above or need further clarifications?

If yes, explain_____

( ) ( ) Are you now under the care of a physician?

If yes, explain_____

( ) ( ) How you been admitted to a hospital or needed emergency care during the past two years?

If yes, explain_____

( ) ( ) Are you taking any medications or herbals?

If yes, explain_____

( ) ( ) Are you Allergic to any of the following?

( ) Latex ( ) Penicillin ( ) Aspirin ( ) Codeine ( ) Iodine ( ) Metal ( ) other_____

( ) ( ) Have you used tobacco? If yes, explain_____

WOMEN (Please Check) ( ) Pregnant ( ) Trying to get pregnant ( ) Taking Oral Contraceptives

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment without fail.

X_____ Date_____

Signature of patient, parent or guardian

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DENTAL HEALTH QUESTIONAIRE

Do your gums hurt or bleed? **Y N**
Do you feel your breath is offensive? **Y N**
Are you happy with the appearance of your teeth? **Y N**
Do you brush regularly? **Y N**
Do you floss regularly? **Y N**

Do you get food caught in your teeth? **Y N**
Are your teeth sensitive? **Y N**
Are you missing teeth? **Y N**
Do you have an unpleasant taste in your mouth? **Y N**

Do you get headaches or migraines? **Y N**
Do you get neck aches or stiff neck? **Y N**
Do you wake up with sore teeth? **Y N**

Do you wake up with a tired jaw? **Y N**
Do you clench or grind your teeth? When? Day/night/Both
Have you thought about straightening your teeth? **Y N**

Does your jaw feel tired after a big meal? **Y N**
Do you ever have popping or clicking in your jaw? **Y N**
Has your jaw ever locked? **Y N**

Do you have difficulty opening wide or yawning? **Y N**
Do you have TMJ problems? **Y N**
Do you have regular pain in your jaw? **Y N**

Do you snore? **Y N**
Have you ever been diagnosed with Sleep Apnea? **Y N**

Do you have sinus problems? **Y N**
Have you ever had a sleep study done? **Y N**

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1. I have a { } low { } moderate { } high fear of going to the dentist.
2. I would say my main concerns with my dental health are: _____

- Please circle services interested in and would like information on -

INVISALIGN - ZOOM WHITENING - SAME DAY CROWNS - LASER PROCEDURES

LASER PROCEDURES - SMILE DESIGN - PERIODONTAL TREATMENT (GUM)

LANDMARK DENTAL GROUP

FINANCIAL AGREEMENT

Thank you for choosing Landmark Dental Group to provide your dental care. Our philosophy in serving people is to be informative, honest, and forthright. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement please do not hesitate to ask our business office staff.

DENTAL INSURANCE: As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

- You must provide us with your insurance information
- Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you and not your insurance company.
- Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.
- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all the services we provide are covered benefits. Benefits differ from one company to another. Fees for noncovered services, along with deductibles and copayments are due at the time of treatment.

PAYMENT POLICY

- We accept cash, personal checks, debit cards, Visa, Mastercard, Discover, American Express, and Care Credit.
- Payment is due at the time of service unless another arrangement has been made through Care Credit financing.
- There will be a $25.00 charge for any returned checks.
- If your insurance company denies your claim, it will be your responsibility to pay the balance due within 30 days.

PATIENTS WITHOUT INSURANCE CONVERAGE: We will provide a written estimate of fees, and payment is expected at each visit for services rendered.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for full payment. In the case of separation or divorced patients, the parent accompanying the child is responsible for payment without any exception. The office will not attempt to collect payment from a parent that is not present in the office at that visit.

RETURNED CHECKS: A $25.00 charge applies when a check is returned by the bank. We understand financial problems may affect timely payment of your balance. In those situations we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

OVERDUE BALANCE: An account with an unpaid balance past 90 days will be sent to a collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt; an interest rate of 21% of the unpaid balance from the last date of service, attorney fees, court fees and any other fees associated with the collection of your debt.

BROKEN OR MISSED APPOINTMENTS: Appointments not kept or changed with less than 48 hours notice are considered broken. Broken appointments prevent others from receiving the dental care they deserve. We take them seriously so please be considerate and inform us in advance if you need to change your appointment.

FEE FOR MISSED APPOINTMENT IF 48 HOUR NOTICE NOT GIVEN: To reschedule or cancel an appointment, you must notify us at least 48 hours in advance to avoid a missed appointment fee of up to $50.00. We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.

RECORDS AND REIMBURMENTS: Original records are the property of this office. If you desire we will provide you with a copy of your record or x-rays.

CONSENT AND AUTHORIZATION: I authorize dental treatment and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understood this document in its entirety, outlining office policies and financial policies. Without any reservations, I agree to abide by the policies outlines herein.

Form Completed by:

Name_____ Signature_____

Witness_____Date_____