Welcome to Family Dentistry and Orthodontics, the office of Dr. Wayne Trowell!

Please print and complete this form before your dental appointment to ensure we get you seated on time – You may also e-mail to AmiDesaiDMD@gmail.com

About You:

Patient Name:____ Nickname: _________________________

SS #: ____________________Drivers License #:________________________ Date of Birth: _____________

Home Address: ____

E-Mail Address: ____

Home Phone: ___________________Cell Phone:____________________Work Phone: ___________________

Occupation: ______________________ Employer: ____

What are your hobbies: ____

Marital Status: □ Single □ Married □ Divorced □ Widowed

Spouses Name: ________________Whom may we thank for referring you to our practice?: ___________________

Is patient a full time student? □ No □ Yes If so please advise name of school and status:_____________________

If Patient is a Child (Under 18 yrs old):

Parent's names/Guardians______________________________ Who has legal custody of the patient ________

Whom do you give permission to accompany patient and make decisions regarding patients treatment at any future dental appointments?

1 - 2 - 3 –

Person Responsible for Account:

Name: ____

Relation to Patient: ____

Billing Address (if different than mailing address): ____

SS #: ____________________Drivers License #:________________________ Date of Birth: _______________

Home Phone: ___________________Cell Phone:____________________Work Phone: ______________________

Primary Dental Insurance:

Subscriber to Insurance Policy: ___________________________________Relation to Patient:________________

Subscribers Date of Birth: ______________________Subscribers SS #:__________________________________

Subscribers Employer: ________________________ Insurance Policy ID #: ______________________________

Insurance Company Name: ________________________ Insurance Policy Group Number:___________________

Insurance Company Providers Phone #: ___________________ Is your policy a PPO plan? □ No □ Yes

Insurance Company Claims Mailing Address: ____

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* Please Note – Our office does not process secondary dental claims or medical insurance claims, however we will provide you with the information needed for you to process directly. *

Medical History:

Last Dental Exam: ___________ **Last Dental X-rays**: ___________

Are you in pain or having discomfort? ☐ Yes ☐ No ☐ Sometimes **Which area?**_________________

Are you fearful of dental treatment? ☐ No ☐ Yes. On a scale of 1 (least) to 10 (most) how would you rate your fear?:

Explain any complications from past dental treatment? _________________________________

Is there anything about the appearance of your teeth that you would like to change?
☐ No ☐ Yes – Please explain: ____

Do you have problems with your jaw joint, such as; pain, sounds, limited opening, locking or popping, clenching or grinding? ☐ No ☐ Yes – Please explain: ____

Do you snore? ☐ No ☐ Yes **Do you wake up choking or gasping?** ☐ No ☐ Yes **Have you ever been tested for sleep apnea?** ☐ No ☐ Yes **Are you interested in a mouth piece to help with snoring issues?** ☐ No ☐ Yes

Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?
☐ No ☐ Yes – Please explain: ____

Have you ever been treated for gum disease or been told you have lost bone around your teeth?
☐ No ☐ Yes **Any family history of periodontal disease in your family?** ☐ No ☐ Yes

How many times a day do you brush your teeth? ______________**Floss per week?**___________

Have you ever taken: Bisphosphonates (Ex. Aredia/Fosamax/Boniva/Actonel/Zometa/Reclast) ☐ Yes ☐ No

Are you allergic to any of the following:
☐ Latex ☐ Penicillin/Amoxicillin ☐ Tetracycline ☐ Aspirin ☐ Dental Anesthetics
☐ Foods: _____________________________ ☐ Other(s):____________________________________

Do you require pre-medication? ☐ Yes ☐ No ☐ Don't know **Do you use tobacco?** ☐ No ☐ Yes

Do you *have* or *have you had* any of the following diseases, medical conditions or procedures?

Y N Aids/HIV/STDs	**Y N** Allergy/Sinus Issues	**Y N** Alzheimer/Dementia	**Y N** Anemia
Y N Arthritis	**Y N** Artificial Joints	**Y N** Asthma/Respiratory	**Y N** Back/Neck Issues
Y N Cancer (Type)_________	**Y N** Codeine Allergy	**Y N** Diabetes	**Y N** Dizziness/Fainting
Y N Glaucoma	**Y N** Hay Fever	**Y N** Head Injuries	**Y N** Heart Attack/Stroke
Y N Heart Disease	**Y N** Heart Murmur	**Y N** Hepatitis A B or C	**Y N** High / Low Blood Pressure
Y N Hydrocodone Sensitivity	**Y N** Jaundice	**Y N** Kidney Disease	**Y N** Liver Disease
Y N Mental Disorders	**Y N** Nervous	**Y N** Pacemaker	**Y N** Pregnancy
Y N Radiation/Cobalt Treatment	**Y N** Rheumatic Fever	**Y N** Rheumatism	**Y N** Severe/Frequent Headaches
Y N Shingles	**Y N** Thyroid Problems	**Y N** TMJ/Jaw Issues	**Y N** Tuberculosis
Y N Tumors/Growths	**Y N** Ulcers	**Y N** Taking Blood Thinners	**Y N** Ever taken Osteoporosis Medications

Please all Medications and any other surgeries or medical conditions you have or ever had:
____
____

Women: Are you taking Birth Control pills? ☐ No ☐ Yes Are you pregnant? ☐ No ☐ Yes Due date? __________

Financial Agreement

Thank you for choosing Family Dentistry and Orthodontics for your dental health needs. We do not want finances to be an issue for our patients. We understand that it is not always possible to pay your dental bill in full so, we would like to explain our financial options. 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.

Please Choose the options that works best for you.

1. Payment is due at the time treatment is rendered. We accept Cash, Check, Credit Card and CareCredit.

2. Dental Insurance- As a courtesy to you we will complete your Insurance form and submit it to the insurance company. Your estimated co-payment for treatment is due at the time treatment is provided. If you fail to bring the required insurance information to your appointments, we will ask that you pay the bill in full and be reimbursed from your insurance company with paperwork provided by our office. Our office does not guarantee that your insurance company will pay for the treatment you receive from our practice. If your claim is denied or the treatment is down-coded and/or alternative benefits given, you will be responsible for paying the full balance amount left on the account at that time. Also, if we are filing an insurance claim for you, we will need a credit card number on file. If insurance has not paid claims within 60 days of filing, we will charge your credit card. Insurance coverage is a contractual agreement between the insurance company and you or your employer. We have no control over this relationship.

   __________ Please initial

   Our office will not enter into a dispute with your insurance company over any claim, although we will provide the necessary documentation your insurance company requests to settle the claim. Our insurance estimate is based on the basic coverage advised by your insurance company, but just as your insurance will advise, there is no guarantee of payment until payment is made. Again, all we can give you is an estimate. We will assist you in dealing with your insurance company, but the ultimate responsibility lies with you.

   If the account is not paid within 60 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.

3. Monthly payment options – If you need to make long-term payments we can offer financing with Care Credit which offers up to 6 months NO INTEREST financing as well as longer terms with low interest rates. You must qualify for this option. Please do not hesitate to ask us about this option. We may conveniently qualify you right here in the office today.

   Returned Checks – A fee of $25.00 will be charged for any returned checks

   Broken Appointments: Please help us keep our costs down. We are a small office and generally see 1 to 2 patients at a time. No-shows are costly for us all. Please be aware of any appoinments made by your and later cancelled with less than 48-hours notice will incur a $75 no-charge.

   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 on my behalf.

By signing below I state that 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 ___________________

☐ Adult Patient ☐ Parent or Guardian ☐ Spouse