DAN DRAKE, DDS & ASSOCIATES

Patient Information:

Patient's Name _____ M F Birthdate ___/___/_____ Age ____ Date ___/___/_____

Name you wish us to call you by: _____ Social Security # ____-____-_____ Spouse's Name: _____

Home Address: Street: _____ City: _____ State_____ Zip: _____

Home Phone: (____) _____-_____ Work Phone: (____) _____-_____ Cell Phone: (____) _____-_____

Email: _____ Emergency Contact : _____ Phone: (____) _____-_____

Patient Employer: _____ yrs ____ Spouse's Employer: _____ yrs_____

How did you find our practice? (circle) Patient Family/Friend Internet TV Ad Yellow Pages Newspaper/Mag Ad Sponsorship Other

If patient/family/friend: Who? _____ What did they say? _____

Dental Insurance Information:

Subscriber Name: _____ Date of Birth___/___/_____ SS# ____-____-_____

Relationship to Patient _____ Insurance Company: _____ Policy #: _____

Medical History and General Health:

Have you had any serious illness or operation? If yes, what? _____

When was the last time you were in the hospital? _____ For what? _____

Are you under any medical treatment now? **Y / N** If yes, for what? _____

Women: Are you pregnant? **Y / N** Taking birth control pills? **Y / N** (if yes, antibiotics may counteract) Hormone therapy? **Y / N**

Are you **allergic** to Penicillin? **Y / N** Any other **allergies**? **Y / N** If yes, what? _____

Do you have or have you ever had the following? If yes, please check:

- ☐ Heart Valve Replacement If yes, when? ____ / ____
- ☐ Prosthetic Joint Replacement If yes, when? ____ / ____
- ☐ Facial Radiation Therapy If yes, when? ____ / ____
- ☐ High or Low Blood Pressure ____ / ____ If yes, are you taking medication? **Y / N** What? _____
- ☐ Anemia or Blood Disorder
- ☐ Arthritis
- ☐ Stroke
- ☐ Hepatitis (Type ____)
- ☐ Venereal Disease
- ☐ AIDS, ARC, HIV+
- ☐ Diabetes Taking Insulin Y / N
- ☐ Emphysema
- ☐ Kidney Trouble
- ☐ Persistent Cough
- ☐ Jaundice or Liver Disease
- ☐ Dizziness or Fainting
- ☐ Tumors or Growth
- ☐ Asthma, Hayfever or Sinusitis
- ☐ Tuberculosis
- ☐ Epilepsy
- ☐ Convulsions
- ☐ Drug Addiction
- ☐ Do you smoke ? ____ Packs / day x ____ years = _____Pack Yrs
- ☐ Do you use smokeless Tobacco?
- ☐ Do you get enough Vitamins? Diet Supplement Both
- ☐ Do you take daily low dose aspirin?

Medications/purpose: _____

_____

Physician's Name _____ Phone Number: (____) _____-_____ Last visit: ____/_____

Yes No Is there any disease, condition or health problem not listed above that we should know about? _____

_____

Patient Info provided by (please sign): _____ Date: ___/_____

We endeavor to make your visits as pleasant as possible. Please tell your friends about your positive experiences!
Please fill out "Dental History" on reverse side and sign prior to proceeding with any treatment.

Dental History:

Yes No Do you have any specific dental concerns? Please explain:_____

_____

Yes No Have you had any serious trouble with or are you unhappy with any previous dental treatment?
If yes, please explain: _____

Previous Dentist Name:_____ Last visit _____ Last x-rays:_____

Yes No Do you have a specific fear of having dental work done? If yes, during dental treatment do you prefer:
Local anesthetic Y / N Nitrous Oxide Y / N Presedation (pill) Y / N IV Sedation Y / N

Yes No Have you been told you have Gingivitis/Periodontis? What year were you first told? ____; last told?____

Yes No Have you been receiving corrective periodontal scaling (pockets over 4 mm) every ____months?

Yes No Have you been referred to/treated by a Periodontist? When first referred?____ When last treated? ____

Yes No Do your gums bleed? How often do you brush? __ x a week How often do you floss? __ x a week

Yes No Have you noticed an unpleasant taste/odor or any new/increasing spaces between/loosening of teeth?

Yes No Do you chew on only one side of your mouth? Left/Right Does this cause pain? Where?_____

Yes No Have you noticed yourself grinding/clenching your teeth? Does this cause pain? Where? _____

Yes No Have you been advised you have TMJ (bite/joint) problems? Have you been treated for TMJ? Y / N

Yes No Are any of your teeth sensitive to cold, sweets or chewing/pressure? Where? _____

Yes No Do you want brighter teeth? If yes, have you ever bleached your teeth? Was it successful? Y / N

Yes No Are you unhappy with your teeth/smile? Y / N If yes, please complete our "Smile Analysis" form.

Yes No Have you had previous orthodontic treatment? When? _____ Have your teeth shifted? Y / N

Yes No Do you snore or have sleep apnea? If yes, do you wear a CPAP or other appliance? Y / N

Yes No Are you curious about BOTOX® or Juvederm® Fillers to smooth wrinkles?

What can we do to make your visits to our office more pleasant? _____

PRIORITY LEVEL OF CARE:

We believe it is appropriate for you to have an awareness of your overall Oral Health and the **PRIORITY LEVEL OF CARE** of indicated treatment necessary to improve and maintain your Oral Health.

Priority Level 1 Care: **IMMEDIATE NEED (Crisis Dentistry)**
pain; decay; broken/cracked tooth; broken/cracked/defective filling; periodontal disease

Priority Level 2 Care: **IMPENDING NEED (Need Based Dentistry)**
sensitive/cracked tooth; unsupported enamel; weak/corroded/oversize filling; occlusal wear into dentin

Priority Level 3 Care: **PREVENTIVE/IDEAL/OPTIMAL ORAL HEALTH CARE (Comprehensive Dentistry)**
cracked tooth (visual); craze lines; weak/corroded/oversize/old filling; worn teeth; collapsed occlusion/closed bite

Priority Level 4 Care: **COSMETIC DENTISTRY**
bleaching; recontour; bonding; porcelain veneers/crowns; replace dark fillings; BOTOX®/Dysport® or Juvederm®/Surgiderm®

We recommend completing Level 1 Care immediately and Level 2 Care as soon as possible, planning for completion of Level 3 Comprehensive Care Treatment on a timely basis, and proceeding with Level 4 Cosmetic Treatment if/when desired.

Please read & sign prior to any treatment:

I will not proceed with any treatment until I have all my questions regarding all options (including no treatment), complications, appointments or fees explained to my complete satisfaction. In order to minimize bookkeeping time and eliminate unnecessary fee increases, all fees for professional services are to be paid at time of treatment unless specific financial arrangements are made in advance. If I request an extended payment (plus interest) arrangement, I authorize obtaining Credit Bureau Reports. I authorize the performance of all procedures necessary in executing the treatment of the above named patient including the administration of anesthetics. I authorize the taking of and showing clinical photographs, and I take full responsibility for all financial obligations incurred. I hereby agree to pay any and all costs of collection for any amounts due, including attorney fees. I acknowledge I have received and/or reviewed the notice of privacy practices.

Signature (Guardian if Patient is a Minor):_____

Method of Payment: ☐ Check ☐ Cash ☐ VISA/MasterCard/Discover/AmEx ☐ Care Credit

Daniel R. Drake, DDS, MICOI
Member Academy of General Dentistry
Fellow & Master International Congress of Oral Implantology
Certified in Conscious IV Sedation

Fredrick W. Costello, DDS, MAGD, AAACD
Fellow & Master Academy of General Dentistry
Accredited Member of American Academy of Cosmetic Dentistry
Past President Florida Academy of Cosmetic Dentistry

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DAN DRAKE, DDS
& ASSOCIATES

Financial Policy Update

ALL ESTIMATED FEES ARE DUE AT THE TIME OF SERVICE

FOR OUR PATIENTS WITH DENTAL INSURANCE:

We will gladly do our best to verify your dental benefits and process your primary and secondary insurance claims with the following understanding and agreement:

- Your dental insurance benefit is a contract between you and your insurance company. Your insurance benefit may be different than the benefit of others insured by the same company.
- All estimated patient copayments and/or patient portions are not guaranteed.
- As part of your contract with your insurance company, you are responsible for meeting your deductibles, payments of all copayments, and any remaining balance after your insurance payment.
- Insurance payments not paid after 90 days will become your complete responsibility and must be paid in full or interest will accrue.

IF WE ARE NOT BILLING YOUR DENTAL INSURANCE:

- We offer up to 5% cash or check discount for treatment paid in full at the time of service. Treatment fee(s) must be in *excess of $500* for that day of service to qualify. (Does not include hygiene visits).

PAYMENT OPTIONS:

- For your convenience, we accept Visa, MasterCard, Discover, Amex, Check or Cash.
- Care Credit, specializing in helping patients finance dental or Invisalign cases.

I have read, understand and agree to all of the above. I have been given the opportunity to ask questions. If I have insurance, I hereby authorize my insurance company to pay my dental benefits directly to Dan Drake, DDS & Associates. I authorize Dan Drake, DDS & Associates to release any medical information to my insurance company as needed to process my insurance claim.

Print name: _____

Sign name: _____

Date: _____