DAN DRAKE, DDS
& ASSOCIATES

Date:_____

Patient's Name _____ Preferred Name:_____

M F Birthdate ____/____/_____ Age _____ Email:_____

Home Address: Street: _____City: _____

State:_____Zip:_____Home/Cell Phone:_____Work Phone:_____

Emergency Contact/relation:_____Phone:_____

Employer:_____ Occupation:_____

Referred by:_____

Dental Insurance Information:

Subscriber Name: _____Date of Birth:____/____/_____

Relationship to Patient _____Insurance Company: _____Member ID:_____

Medical History and General Health:

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

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

Y / N: Heart Valve Replacement If yes, when?_____	Y / N: Prosthetic Joint Replacement If yes, when?_____	Y / N: Facial Radiation Therapy If yes, when?_____
Y / N: Diabetes, taking insulin? Y / N	Y / N: Asthma, Hay fever or Sinusitis	Y / N: Jaundice or Liver disease
Y / N: High Blood Pressure	Y / N: Low Blood pressure	Y / N: Anemia or blood disorder
Y / N: Stroke	Y / N: Hepatitis (Type ____)	Y / N: AIDS, ARC, HIV+
Y / N: Epilepsy	Y / N: Emphysema	Y / N: Tumors or growth
Y / N: Tuberculosis	Y / N: Convulsions	Y / N: Dizziness or Fainting
Y / N: Smoking/Tobacco Use If yes, years of use _____	Y / N: Arthritis	Y / N: Drug Addiction

Patient Signature: _____

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Medication Supplement page

If NO prescriptions or supplements taken on a daily/regular basis then please check this box: ☐

Patient Name: _____ DOB: _____

Medication:	Dosage:	Purpose:

Please ask for an additional page if needed.

Dental Information:

Have you experienced dental pain recently? Y / N If Yes, please explain _____

_____

Are you UNHAPPY with your smile? Y / N If Yes, please explain _____

_____

Interested in straightening your teeth (Invisalign)? Y / N If Yes, please explain _____

_____

Interested in Whitening? Y / N

Interested in IV Sedation, Oral Sedation, Laughing Gas? Y / N

Do you grind or clench at night or have TMJ pain? Y / N

When was your last dental cleaning?_____ X-Rays?_____

Have you been diagnosed in the past with gum or periodontal disease? Y / N

Name of previous dentist:_____

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 and risks, appointments or fees explained to my complete satisfaction. All fees for professional services are to be paid at time of treatment unless specific financial arrangements are made in advance. 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):_____

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Financial Policy

ALL ESTIMATED FEES ARE DUE AT THE TIME OF SERVICE

Membership

The practice offers an annual membership program that provides significant discounts to our normal and customary fees. Many patients do the "math" and realize the program may be more financially advantageous than a traditional dental insurance plan. If interested, please inquire with our lovely front desk staff.

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 co payments 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 will be sent to a collections agency.**
- We cannot file with Medicare, Medicaid, or HMOs.

Payment Options:

- For your convenience, we accept Visa, MasterCard, Discover, American Express, Check and Cash
- Care Credit, specializing in helping patients finance dental care, including Invisalign

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 and Associates to release any medical information to my insurance company as needed to process my insurance claim.

Print Name: _____

Sign Name: _____

Date: _____