

DR. NANCY R. CHAFFEE, D.D.S., M.S., P.L.L.C.
ESTHETIC, IMPLANT, AND RECONSTRUCTIVE PROSTHODONTICS

Please Complete All Forms Completely and Sign

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
Gender: _____ Marital Status: _____ Student: Yes or No
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ (Cell/Other): _____
Preferred appointment times: Morning Afternoon Evening Any Time M T W T F S
Address: _____
Street Apartment #
City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Dental Office Yellow Pages Newspaper School Work Other _____
Name of person or office referring you to our practice: _____
What dental concerns brought you to our office?: _____
Date of Last Dental Exam: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment medical POA
Name: _____
 Male Female Married Single Child Other _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
Address: _____
Street Apartment #
City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment
Employer Name: _____ Occupation: _____
Address: _____
Street City, State Zip Code Phone

Insurance Information

[We do not accept or file insurance, however, if you provide us with your insurance information, we can you provide you with the appropriate insurance claim form for you to submit]

Primary

Name of Insured: _____ Last First MI Is insured a patient? Yes No
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: Self Spouse Child Other _____
Insurance Plan Name and Address: _____

Annual update of changes:

Signature: _____ Date: _____
Signature: _____ Date: _____

MEDICAL HISTORY

PATIENT NAME: _____ **Date of Birth:** _____

GENERAL INFORMATION

- 1. Has there been any change in your general health within the past year? YES NO
- 2. Have you had any serious illness or operation? YES NO
- 3. Have you been hospitalized within the last 2 years? YES NO
Explain: _____

4. Physician's name: _____

- Hormone Therapy YES NO
- Cancer/Tumors YES NO
If yes, type _____
- Joint Replacement YES NO
- Back or Neck Injury YES NO
- Arthritis YES NO
- Blood Disorder or Anemia YES NO
- Abnormal Bleeding After Extractions YES NO
- History of Transfusions YES NO
- Bruise Easily YES NO
- Swollen Lymph Nodes YES NO
- History of Radiation Treatment YES NO
- AIDS/HIV YES NO
- Venereal Disease YES NO
- Have you been an IV drug user? YES NO
- Head or Jaw Injury YES NO
- Frequent Headaches YES NO
- Dry Mouth YES NO
- Bad Breath YES NO

DO YOU HAVE OR HAVE YOU HAD? Please answer Yes or No

- High Blood Pressure YES NO
- Low Blood Pressure YES NO
- History of Heart Attack(s) YES NO
- Heart Murmur YES NO
- Mitral Valve Prolapse (MVP) YES NO
- Heart Surgery – Bypass or Valve Replacement YES NO
- Chest Pain on Exertion – Angina YES NO
- Shortness of Breath YES NO
- Swollen Ankles YES NO
- Rheumatic Heart Disease or Fever YES NO
- History of Stroke(s) YES NO
- Pacemaker YES NO
- Nervous Disorders/Psychotherapy YES NO
- Epilepsy or Convulsions/Seizures YES NO
- Fainting Spells YES NO
- Numbness YES NO
- Respiratory Disease YES NO
- Tuberculosis YES NO
- Sinus Trouble YES NO
- Seasonal Allergies YES NO
- Pneumonia YES NO
- Asthma or Emphysema YES NO
- Chronic Cough, Sore Throat or Cough Up Blood YES NO
- Do you smoke? If yes, packs per day _____ YES NO
- Kidney Disease YES NO
- Indigestion or Stomach or Intestinal Trouble YES NO
- Jaundice or Hepatitis YES NO
- Liver Disease YES NO
- Ulcers YES NO
- Diabetes YES NO
- Frequent Urination and/or Excessive Thirst YES NO
- Thyroid Disease YES NO

Do you have a health condition that requires you to take PRE-MEDICATION prior to dental treatment?

If Yes: Medical Condition: _____
Prescription: _____

ALLERGIES

- Are you allergic to or had a reaction to:
- Local anesthetic (novacaine) YES NO
 - Penicillin YES NO
 - Other antibiotics YES NO
 - Sulfa drugs YES NO
 - Barbiturates, sleeping pills YES NO
 - Aspirin YES NO
 - Iodine YES NO
 - Codeine or other narcotics YES NO
 - Metals (rings, earrings) YES NO
 - Latex YES NO
 - Other allergies YES NO

WOMEN ONLY:

- Are you pregnant? YES NO
- Is yes, how many months? _____
- Are you breastfeeding? YES NO
- Do you have any problems associated with your menstrual period? YES NO

Please list all medications you are currently taking:

Do you have any disease, condition, or problem not listed, or that needs further explanation? YES NO

In case of an Emergency, Please Contact: _____ **Relationship to Patient:** _____

Primary Contact Number: _____ Alternate Number: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. I understand that if I ever have any change in my health, I will inform the doctors at or prior to my next dental appointment.

Signature of Patient, Parent, or Guardian: _____ Date: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. Every effort to ensure a clear understanding of the proposed treatment and the fees for the treatment will be made in advance of initiating treatment. Payment can be made by cash, check, Visa or Mastercard. If the cost of treatment is \$500.00 or less, the entire amount is due in full at the time treatment is performed. If the cost of treatment is greater than \$500.00, at least **one-third** of the total cost of the treatment is due at the time of initial treatment, with the balance to be paid in monthly installments throughout the course of treatment with the final installment due at completion of the treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash or by credit card at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. Insurance is a contract between a patient and their insurance company. This office will help prepare the patient's insurance forms and assist in making collections from insurance companies. We will request that any such collections be paid directly to the patient. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of twelve months from the date of the presentation of the treatment plan.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, as outlined above. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____
Signature of patient, parent or guardian

Relationship to Patient: _____

_____ Date: _____
Signature of guarantor of payment/responsible party

Relationship to Patient: _____