REFLECTIONS
FAMILY AND COSMETIC DENTISTRY

Patient Information:

Patient Name: _____ Preferred Name _____ Gender:_____ Date: _____
Last, First MI
Birth Date: _____ Family Status: _____ Social Security #: _____ Email Address _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Number: _____

Address: _____
Street Apt # City State Zip Code
Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code
Phone: _____

Whom may we thank for referring you to our practice? _____

Health Information

PLEASE LIST CURRENT MEDICATIONS YOU ARE TAKING: _____

_____

Date of Last Dental Visit: _____ **Reason for this visit:** _____

Have you ever had any of the following? Please check YES or NO:

Y	N		Y	N		Y	N		Y	N	
☐	☐	AIDS	☐	☐	Excessive Bleeding	☐	☐	Hypoglycemia	☐	☐	Sickle Cell Anemia
☐	☐	Alzheimer's Disease	☐	☐	Excessive Thirst	☐	☐	Jaundice	☐	☐	Sinus Problems
☐	☐	Anemia	☐	☐	Fainting	☐	☐	Kidney Disease	☐	☐	Stomach Problems
☐	☐	Arthritis	☐	☐	Fever Blisters	☐	☐	Liver Disease	☐	☐	Stroke
☐	☐	Artificial Joints/Hips	☐	☐	Frequent Cough	☐	☐	Lung Disease	☐	☐	Swelling of Feet / Ankles or Hands
☐	☐	Artificial Heart Valve	☐	☐	Glaucoma	☐	☐	Mental Disorders	☐	☐	Thyroid Disease
☐	☐	Asthma	☐	☐	Growths	☐	☐	Mitral Valve Prolapse	☐	☐	Tuberculosis
☐	☐	Blood Disease	☐	☐	Have you ever taken Phen-Phen/Redux?	☐	☐	Nervous Disorders	☐	☐	Tumors
☐	☐	Blood Transfusion	☐	☐	Hay Fever	☐	☐	Pacemaker	☐	☐	Ulcers
☐	☐	Bruise Easily	☐	☐	Head Injuries	☐	☐	Pain in Jaw Joints	☐	☐	Venereal Disease
☐	☐	Cancer	☐	☐	Heart Disease	☐	☐	Pregnancy Due date:_____	☐	☐	Yellow Jaundice
☐	☐	Chemotherapy / Radiation	☐	☐	Heart Trouble	☐	☐	Pre Med	☐	☐	Allergy: Penicillin
☐	☐	Chest Pain/Angina	☐	☐	Heart Murmur	☐	☐	Psychiatric Care	☐	☐	Allergy: Latex
☐	☐	Cold Sores	☐	☐	Heart Surgery	☐	☐	Radiation Treatment	☐	☐	Allergy: Sulfa Drugs
☐	☐	Cortisone Medicine	☐	☐	Hemophilia	☐	☐	Recent Weight Loss	☐	☐	Allergy: Ibuprofen
☐	☐	Diabetes	☐	☐	Hepatitis A / B / C	☐	☐	Respiratory Problems	☐	☐	Allergy: Tetracycline
☐	☐	Dizziness	☐	☐	Herpes	☐	☐	Rheumatic Fever	☐	☐	Allergy: Aspirin
☐	☐	Drug Addiction	☐	☐	High Blood Pressure	☐	☐	Rheumatism	☐	☐	Allergy: Codeine
☐	☐	Emphysema	☐	☐	Low Blood Pressure	☐	☐	Scarlet Fever	☐	☐	Allergy: Epinephrine
☐	☐	Epilepsy or Seizures	☐	☐	HIV	☐	☐	Shortness of Breath	☐	☐	Allergies:_____

Do you have a specific dental problem? Describe_____ Yes No
Do you have dental examinations on a routine basis? Last visit_____ Yes No
Do you have active decay or gum disease?_____ Yes No
Do you brush and Floss on a routine basis? Discuss_____ Yes No
Do your gums ever bleed? Discuss_____ Yes No
Do you like your smile? Why?_____ Yes No
Does food catch between your teeth? Any loose teeth?_____ Yes No
Do you want to keep your remaining teeth?_____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
Have your past experiences in a dental office always been positive?_____ Yes No
Do you smoke or chew? Any sores or growths in you mouth? Discuss._____ Yes No
Name of previous dentist (optional):_____ Yes No
Date of last full mouth x-rays (16 small films or panoramic):_____ Yes No

Note to Women: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician or gynecologist for assistance regarding additional or alternative methods of birth control.

Have you ever had any complications following dental treatment? ☐ Yes ☐ No If yes, please explain: _____
Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____
Are you now under the care of a physician? ☐ Yes ☐ No If yes, please explain: _____
Name of Physician: _____ Phone: _____
Do you have any health problems that need further clarification? ☐ Yes ☐ No If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian X_____ **Date:**_____

Reviewed by Dr:_____ **Date:**_____

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Responsible Party Information

Name: _____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Social Security #: _____ Birth Date: _____ Driver License#: _____

Phone (Home) #: _____ (Work)#: _____ Ext#: _____ (Cell)#: _____

Address: _____
Street Apartment # City State Zip Code

In case of emergency, whom shall we call: Name: _____ **Relationship:**_____
Phone Number:_____

Insurance Information

Primary Insured Persons Information:

Name: _____ Birth Date: _____ ID or SS#: _____
Last First MI

Address: _____
Street City State Zip Code

Employer Name & Address: _____ Insurance Group#: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Phone Number:_____

Secondary Insured Persons Information:

Name: _____
Last First MI
Birth Date: _____ ID#: _____

Address: _____
Street City State
Zip Code
Employer Name & Address: _____
Group#)#:_____ Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____
Insurance Plan Name & Phone Number:_____

Consent for Services

As a condition of treatment by this office, I understand 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. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time the services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company. A service charge of 1 ½% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 30 days of treatment date. I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination. In consideration of the professional services rendered to me, or at my request, by the Doctor and/or her staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or her assignee, at the time said services are rendered, or within five (5) days of billing **if** credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees.

IT IS OUR POLICY TO CHARGE $50.00 FOR MISSED APPOINTMENTS WITHOUT 24 HOUR NOTICE. THIS FEE MUST BE PAID PRIOR TO SCHEDULING ANY FUTURE APPOINTMENTS. 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.

X_____ **Date:** _____ **Relationship to Patient:** _____
Signature of Responsible Party / Parent or Guardian

In order for us to help prepare your insurance forms and assist in making collections from insurance companies to credit to your account, we will need the following authorizations: I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my claims:

X _____
Signature of Responsible Party/Parent or Guardian

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Dr. Cheryl Meregillano D.D.S., Inc.

X_____