WELCOME TO BORDERVIEW DENTAL

The benefits of a happy, healthy smile are immeasurable!
Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely.
The better we communicate, the better we can care for you.

1 ABOUT YOU

Name _____

Preferred Name_____ ❑Male ❑Female

❑Single ❑Married ❑Divorced ❑Widowed ❑Seperated

Birthdate_____ Age_____ SS#_____

Address _____

City _____ State_____ Zip_____

Email _____

Home #_____Work #_____

Mobile # _____Fax # _____

Whom may we thank for referring you?_____

Other family members seen by us _____

Date of last dental visit _____

Employer _____Ph #_____

Employer Address _____

How long employed there? _____

2 RESPONSIBLE PARTY

Name _____Relation_____

Home # _____ Work # _____

Mobile # _____ DOB _____

Email _____

Billing Address _____

City _____State_____ Zip _____

3 SPOUSE INFO

Name _____Relation_____

Home # _____ Work # _____

Mobile # _____ DOB _____

Email _____

4 INSURANCE

Provider Name _____

Provider Address _____

City _____ State_____ Zip _____

Group # _____

Insured's Name _____ Relation _____

Insured's DOB _____ Insured's ID# _____

Insured's Employer _____Insured's Ph#_____

SECONDARY INSURANCE

Provider Name _____

Provider Address _____

City _____ State_____ Zip _____

Group # _____

Insured's Name _____ Relation _____

Insured's DOB _____ Insured's ID# _____

Insured's Employer _____ Insured's Ph# _____

5a MEDICAL HISTORY

Do you have a personal physician? ❑Yes ❑No

Physician's Name _____

Phone # _____ Last visit date _____

Are you currently under the care of your physician? ❑Yes ❑No

If yes, please explain _____

_____

IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT?

Name _____Relation_____

Home # _____ Work # _____

Thank you for filling out this form completely. It will allow us to serve you more effectively. If you have a question at any time, please ask us. We are happy to help.

5b MEDICAL HISTORY

Your current physical condition ❑Good ❑Fair ❑Poor

Do you smoke or use tobacco in any form? ❑Yes ❑No

Are you taking any prescription , over the counter, or herbal supplement drugs? ❑Yes ❑No

Please list each one _____

_____

Have you ever taken Phen-Fen (also known as Redux or Pondimin)?

❑Yes ❑No If yes, When? _____

FOR WOMEN ONLY

Are you taking birth control pills? ❑Yes ❑No

Are you pregnant? ❑Yes ❑No Week #_____

Are you nursing? ❑Yes ❑No

HAVE YOU EVER HAD ANY OF THE THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Yes	No	Abnormal Bleeding	Yes	No	Herpes/Fever Blisters
Yes	No	Alcohol/Drug Abuse	Yes	No	High Blood Pressure
Yes	No	Anemia	Yes	No	HIV+ / AIDS
Yes	No	Arthritis	Yes	No	Hospitalized
Yes	No	Artificial bones, Joints or Valves			for any reason
			Yes	No	Venereal Disease
Yes	No	Asthma	Yes	No	Kidney Problems
Yes	No	Blood Transfusion	Yes	No	Liver Disease
Yes	No	Cancer / Chemotherapy	Yes	No	Low Blood Pressure
Yes	No	Colitis	Yes	No	Lupus
Yes	No	Congenital Heart Defect	Yes	No	Mitral Valve Prolapse
Yes	No	Diabetes	Yes	No	Pacemaker
Yes	No	Difficulty Breathing	Yes	No	Psychiatric Problems
Yes	No	Emphysema	Yes	No	Radiation Therapy
Yes	No	Epilepsy	Yes	No	Rheumatic Fever / Scarlet Fever
Yes	No	Fainting Spells			
Yes	No	Frequent Headaches	Yes	No	Seizures
Yes	No	Glaucoma	Yes	No	Shingles
Yes	No	Hay Fever	Yes	No	Sickle Cell Disease
Yes	No	Heart Attack	Yes	No	Sinus Problems
Yes	No	Heart Murmur	Yes	No	Stroke
Yes	No	Heart Surgery	Yes	No	Thyroid Problems
Yes	No	Hemophilia	Yes	No	Tuberculosis (TB)
Yes	No	Hepatitis	Yes	No	Ulcers

Please list any other medical condition(s) that you have had _____

_____

_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Yes	No	Aspirin	Yes	No	Erythromycin	Yes	No	Penicillin
Yes	No	Codeine	Yes	No	Jewelry/Metal	Yes	No	Tetracycline
Yes	No	Dental Anesthetics	Yes	No	Latex	Yes	No	Other

Please list any other drugs / materials that you are allergic to: _____

_____

6 DENTAL HISTORY

Why have you come to the dentist today? _____

_____

Has your doctor told you that you require antibiotics before dental treatment? ❑Yes ❑No

Are you currently in pain? ❑Yes ❑No

Have you ever had a serious or difficult problem associated with any previous dental work? ❑Yes ❑No

Do you or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? ❑Yes ❑No

Does dental work cause nervousness or anxiety? ❑Yes ❑No
If yes, are you interested in nitrous oxide / mild sedative?
❑Yes ❑No

Your current dental health is ❑Good ❑Fair ❑Poor

Do you like your smile? ❑Yes ❑No

Do your gums ever bleed? ❑Yes ❑No

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of tooth brush bristles? ❑Hard ❑Medium ❑Soft

7 DISCLAIMER

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

In the event that payment in full for charges incurred is not made, I agree to pay all costs of collection including a 50% collection fee, attorney fees, and court costs.

_____

Signature Date

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

Borderview DENTAL

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials_____ Date_____

Doctors comments _____

MEDICAL HISTORY UPDATE

Date_____ Comments _____ Signature_____

Date_____ Comments _____ Signature_____

Date_____ Comments _____ Signature_____

Welcome. We are glad you are here.

To better serve you, please take a couple minutes to answer the following questions. Thank you.

Borderview DENTAL

Please check any of the following problems that apply to you:

- o Sensitivity (hot cold, or sweet)
  If so, which teeth?
- o Headaches, earaches, neck pain
- o Grinding or clenching teeth
- o Bleeding, swollen, or irritated gums
- o Loose, tipped, or shifting teeth
- o Bad breath

Do you have or have you had any of the following?

- o Dentures
- o Partial dentures
- o Periodontal (gum) treatment

Please share the following approximate dates:

Your last cleaning: _____

Your last oral cancer screening: _____

Your last complete x-rays: _____

Who was your last dentist?

Name: _____

City: _____ State: _____

Phone: _____

What are the most important things to you about your smile and dental health?

If you could whiten your teeth, at a cost that anyone could afford, would you like to?

Do you smoke or use chewing tobacco?

o Yes o No

If yes, how much? And, for how long?

If you could change your smile, would you:
(please check all that apply)

- o Make your teeth whiter
- o Make your teeth straighter
- o Close spaces between teeth
- o Replace black metal fillings with tooth colored restorations
- o Repair chipped teeth
- o Replace missing teeth
- o Replace old crowns that don't match

On a scale of 1-5, with 5 being the highest rating:
(please circle the number that best applies)

How important is your dental health to you?

1 2 3 4 5

How would you rate your current dental health?

1 2 3 4 5

Where do you want your dental health to be?

1 2 3 4 5

Why did you leave your previous dentist?

What is the most important thing to you about your dental visit today?

Borderview Dental

Office Policies and Procedures

I _____, acknowledge and understand the following:

- To keep the cost of healthcare as low as possible, uninsured patients are required to provide payment in full at the time of service unless prior arrangements have been made. We accept payment by cash, check, Visa, MasterCard, American Express, Discover and Care Credit.

- As a courtesy to our patients we will bill your insurance company on your behalf. If you have insurance please understand that the total bill is ultimately your responsibility. The contract is between the insured policy holder and the insurance company. Borderview Dental cannot guarantee what percentage of your final bill the insurance company will pay. We can only estimate on what your insurance company does not pay.

- I agree to pay all charges within 45 days. If I require an exact estimate before beginning treatment, Borderview Dental can request a predetermination from my insurance company.

- I understand that Borderview Dental offers only composite (white) fillings. Most insurance companies only pay the fee for amalgam (silver) fillings on posterior (premolars and molars) teeth. This will result in an increased insurance co-payment which I am responsible for.

- I understand that some treatment items are either not covered or are only partially covered by most insurance companies and I agree to pay for these items. These may include: Nitrous oxide (60/hr), teeth whitening, fluoride and sealants if older than 14, periodontal maintenance, study models, or night guards.

- I will be responsible for a $35 charge on any check returned for insufficient funds.

- When your appointment is made the time is booked for you. It is imperative that Borderview Dental receives at least 48 hour notice for cancellations. I understand that I may be responsible for a $50 charge for a no-show or canceled appointment without 48 hour notice.

Patient Signature _____ Date _____
(parent or legal guardian if patient is a minor)