Welcome to our dental family. We are committed to providing you with the very finest of quality modern dentistry. We take a comprehensive approach to your overall health and wellness. While it may appear our main focus is on your teeth and gums we'll also evaluate the airway, the jaw joint and muscles, the bite, and your smile. We are concerned about you as a whole person and will always strive to provide you with the individual care you require. You can be assured we will always offer the most conservative, esthetic and highest quality care. Take a moment to complete these forms completely. The more we understand you and the better we communicate, the better we can serve you.

ROD GLEAVE D.M.D
Comprehensive Dental Wellness

Rod Gleave & Team

1. All About You

Name _____ Today's Date _____

Preferred Name _____ Email Address _____

Home Address _____ City _____ State _____ ZIP _____

Home Phone _____ Cell Phone _____

Best Phone # to contact me during the day _____ Best Times _____

Would you like appointment reminders? (circle any) Email Text message Phone Call

Social Security # (if insured) _____ Birth Date _____

Employer _____ Phone _____

Emergency Contact _____ Phone _____

How were you referred to our office? _____

2. Spouse Information *(complete only if insurance is in spouse's name)*

Name _____ Phone _____

Mailing Address _____ City _____ State _____ ZIP _____

Social Security # _____ Birth Date _____

Employer _____ Occupation _____

Business Address _____ Phone _____

3. Dental Insurance

I understand that my insurance contract is between myself and the insurance company, and I understand the patient or responsible person is ultimately responsible for all charges not paid by the insurance company.

I understand that my insurance claim will be filed by the dental office as a courtesy to the patient. Any unpaid claims will need to be resolved within 60 days. All unpaid balances past 60 days will be charged 1.5% per month interest. I understand that not all dental services are covered in the contract, and that some insurance companies arbitrarily select certain services they will not cover.

I understand that having double coverage does not always guarantee payment from both insurances. Very often the second insurance will have exclusions or will not pay at all.

I understand the quoted co-payment is just an estimate based on our experience. Please understand that each insurance company has multiple fee and benefit schedules and it is impossible for us to know just which plan your employer has chosen.

4. Financial Policy

I agree to pay a $40.00 fee on all returned or canceled checks.

I understand payment in full or the estimated insurance co-payment is expected on or before the day treatment is rendered. If not a signed financial arrangement must be made.

I understand we offer a bookkeepers discount only if full payment is made prior to day of appointment, (5% cash or check and 2.5% by credit card). No discounts will apply to payments made on day of service.

I understand there is a No Show / Cancellation fee for all appointments. The fee is determined by the amount of time reserved for the visit. ($25-$500). If unsure about your schedule, wait to make the appointment.

In the event it becomes necessary to make monthly payments, I agree to pay a $25 fee for any month I miss the agreed upon payment, in addition to the finance charges.

I agree that failure to make a payment or to contact us for 2 consecutive months will result in your account being referred to our collection attorney. All payment arrangements must then be made with them. All collection fees will be added in.

In the event my account is not paid as agreed, I agree to pay a collection fee of 40% of my outstanding balance in addition to my balance. Additional collection agency fees, attorney's fees, and court costs will also be added.

If unsure about the cost of treatment, your insurance coverage, or your payment options, please ask to speak with the financial coordinator prior to beginning treatment. Once treatment is rendered, I agree and understand I am responsible for all charges.

Responsible Party Signature _____ Date _____

Witness Signature (team member) _____ Date _____

5. Dental History

Why have you come to the dentist today? _____

Have you had a previous bad experience at the dentist? Why? _____

Rate your current level of dental health? (circle one) Excellent Good Fair Poor

What level of dental health would you like to achieve? _____

Is it important to you to avoid losing your teeth and having to use a denture? Yes ☐ No ☐ Indifferent ☐

I'm most concerned with: ☐ price of treatment ☐ what insurance pays ☐ receiving quality, conservative, esthetic care?

If you could change anything about your teeth, what would it be? _____

Hygiene

What is the approximate date of last cleaning? _____

Have you ever been treated for periodontal (gum) disease? Yes ☐ No ☐ Gum Surgery? Yes ☐ No ☐

Do you floss? Daily ☐ Weekly ☐ Seldom ☐ Never ☐ Do your gums bleed when you brush? Yes ☐ No ☐

Do you get food stuck between your teeth? Yes ☐ No ☐ Are you concerned with the odor of your breath? Yes ☐ No ☐

Do you smoke? Yes ☐ No ☐ Do you chew tobacco? Yes ☐ No ☐

Teeth

Are your teeth sensitive to cold, hot, or sweets? Yes ☐ No ☐ Are any teeth sensitive to biting? Yes ☐ No ☐

Are you concerned with having silver-mercury fillings in your teeth? Yes ☐ No ☐

Do you dislike the way any of your previous crowns or fillings look? Why? _____

Smile

Are you dissatisfied with the appearance of your teeth or smile? Yes ☐ No ☐

If you could change anything about your teeth or smile, what would it be? _____

Would you like to whiten your teeth? Yes ☐ No ☐ Have you tried to whiten in the past? Yes ☐ No ☐

Your Bite

Are you aware or might suspect you clench or grind your teeth? Yes ☐ No ☐

Have you ever experienced pain or noise in your jaw joint? Yes ☐ No ☐

Do you get headaches more frequent than once a month? Yes ☐ No ☐

Do you chew gum frequently? Yes ☐ No ☐ Have you ever or do you now wear a nightguard or bite splint? Yes ☐ No ☐

Airway or Sleep / Breathing Disorders

Do you snore or suspect you may? Yes ☐ No ☐ Have you been diagnosed for sleep apnea? Yes ☐ No ☐

Sedation

Has fear of discomfort kept you from seeking regular dental care? Yes ☐ No ☐

On a scale of 1-10, how apprehensive are you about dental care? (10 being greatest) _____

Would you like to be sedated? Yes ☐ No ☐ If yes, which method would you prefer? IV ☐ Oral ☐ Nitrous Oxide ☐

Any other concerns before moving forward? _____

6. Medical History

Patient Name: _____

Are you currently or within the past 2 years been under the care of a physician? Yes ☐ No ☐

Please explain _____

List all prescription / over-the-counter medications: _____

Are you allergic to: (circle) Penicillin Codeine Hydrocodone Dental Anesthetic Metals Latex Cephlasporins Erythromycin Asprin Ibuprofen Sulfa Other: _____

Do you require antibiotics prior to dental work for an artificial joint or heart condition? Yes ☐ No ☐ Why? _____

Have you ever taken Fosomax or other like medicine to treat osteoporosis? Yes ☐ No ☐

Do you have or have you ever had any of the following? (circle any that apply)

Heart disease	Lung disease	Epilepsy or seizures
Heart murmur	Osteoporosis	Artificial joints
Rheumatic fever	Asthma	Hepatitis
Artificial heart valve	Psychiatric therapy	Chemo / radiation therapy
Mitral valve prolapse	Difficulty breathing	Kidney disorder
Low / High blood pressure	Substance abuse	Diabetes
Stroke / TIA	Steroids / prednisone	Blood disease or disorder
Head injury	Immune system disorder	Oral herpes / cold sore
Sinus disease / surgery	Bruise easily	AIDS or HIV positive

Any other medical or heath concerns we should be aware of? _____

For women:

Are you taking birth control pills? Yes ☐ No ☐ (Some antibiotics may interfere with efficacy)

Are you pregnant or is there a chance you may be pregnant? Yes ☐ No ☐ Week # _____

Are you nursing? Yes ☐ No ☐

Responsible Party Signature _____ Date _____

7. Consent for Treatment

I authorize Dr Gleave and this office to perform any necessary dental services with my informed consent and assume all risks associated with treatment in the hope of achieving better health.

I understand there are certain risks associated with the use of local anesthetic which can lead to bruising, muscle soreness, cardiac stimulation, temporary or even permanent numbness to the lips or tongue. Also with basic dentistry such as fillings and cleanings the teeth may remain sensitive or even possibly painful after treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and soft tissues may also be sensitive or painful during after treatment. Although rare, it is also possible for the tongue, cheek, or other oral tissues to be inadvertently abraded or lacerated during routine dental procedures.

I understand that as part of the dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may in rare cases, require bronchoscopy to ensure safe removal.

Once again, welcome to our office and we look forward to serving you and your loved ones for the years to come. We want you to know we are dedicated to providing you with the highest standards of quality modern care. From sterilization methods to the most proven, newest materials and procedures, you can feel confident you are receiving the most excellent dental care possible. If for any reason you are not satisfied with any work for any reason, please let us know. Your complete satisfaction is our foremost concern.

_____ _____

Responsible Party Signature Date

_____ _____

Witness Signature (team member) Date