Oswego Dental Specialists Welcomes You

Patient Information

Date_____ Social Security Number_____
Name_____
(Last, First, M.I.)
Address_____
City, State, Zip_____
Sex: ___M ___ F Birthdate_____ Marital Status_____
Employer/School:_____
Occupation:_____
Whom may we thank for referring you?_____

Contact Information

Home:_____ Work:_____
Cell:_____Email:_____
Emergency Contact:_____Phone:_____
Relationship:_____

*Primary **Dental** Insurance*

Subscriber Name:_____ SS#_____
Relation to Patient:_____Birthdate:_____
Address (if different from patient)_____
City_____State_____Zip_____
Responsible Person Employer_____
Business Address_____Phone_____
Insurance Company_____
Group/Plan#_____ Member ID_____
Other dependents covered under this plan:_____

*Additional **Dental** Insurance*

Is patient covered by additional insurance? ___Y ___N
Subscriber Name:_____ SS#_____
Relation to Patient:_____Birthdate:_____
Address (if different from patient)_____
City_____State_____Zip_____
Responsible Person Employer_____
Business Address_____Phone_____
Insurance Company_____
Group/Plan#_____ Member ID_____
Other dependents covered under this plan:_____

Oswego Dental Specialists
Health History

Patient Name_____ **Birth date** _____

DENTAL HISTORY

What is the reason for today's visit? _____

When was your last visit to a dentist? _____

Have past dental experiences been satisfactory? _____

How do you feel about the appearance of your teeth? _____

Do you have or have you had any of the following? (Please check all that apply to you)

- o Bleeding gums
- o Broken fillings
- o Chronic bad breath
- o Decayed teeth
- o Food catches between teeth
- o Grinding or clenching of teeth
- o Injury to teeth or jaw
- o Loose teeth
- o Orthodontic treatment
- o Periodontal treatment
- o Painful or locking jaw
- o Sensitivity to sweet, hot, cold, biting
- o Sores, growths or swelling in mouth

MEDICAL HISTORY

Do you have or have you had any of the following? (Please check all that apply to you)

- o Anemia
- o Arthritis, rheumatism
- o Artificial heart valves
- o Artificial joints
- o Asthma, sinus problems
- o Autoimmune disease
- o Back problems
- o Blood disease
- o Abnormal bleeding, prolonged healing, bruising easily
- o Cancer
- o Chemical dependency
- o Chemotherapy
- o Circulatory problems
- o Cortisone treatments/steroids
- o Cough, persistent/chronic
- o Cough up blood
- o Diabetes
- o Epilepsy/seizures
- o Fainting
- o Glaucoma/eye disorders
- o Headaches, migraine headaches
- o Heart murmur
- o Heart disease (describe)
- o Hemophilia
- o Hepatitis/liver diseases/jaundice
- o High blood pressure
- o Low blood pressure
- o HIV positive
- o AIDS
- o Kidney disease
- o Mitral value prolapse
- o Malignancy or tumor/cyst
- o Nervous disorders
- o Pacemaker
- o Psychiatric care
- o Radiation treatment
- o Respiratory disease
- o Rheumatic fever/rheumatic heart disease
- o Shortness of breath
- o Skin rash
- o Stroke
- o Congestive heart failure
- o Thyroid disease
- o Tobacco habit
- o Tuberculosis
- o Ulcer/digestive disorders
- o Venereal disease

Physician_____Tel #_____

Date of last physical exam:_____

Please list all medications you are currently taking as well as over-the-counter medications, herbal remedies, vitamins, homeopathic remedies: _____

_____

Allergies/reactions to medications, or other allergies? _____

(Women) Are you pregnant? _____ Nursing?_____ Taking birth control pills?_____

Are you presently under a physician's care? _____Explain_____

Do you consider yourself to be in good health?_____

Please describe any impending operations, recent injuries or other information the dentist should be aware of:

_____

Patient signature_____Date_____ Dentist's initials_____

Oswego Dental Specialists
Financial Agreement

For our patients with Dental Insurance

We will gladly verify your dental benefits and process your primary and secondary claims with the following agreement:

- Your dental insurance is an agreement between you and your insurance company.
- All patient co-payments and patient portions are only an estimate/never a guarantee of payment.
- As part of your contract with your insurance company, you are responsible for all out of pocket expenses/portions/copayments/deductibles. **All patient co-payments and estimated patient portions are due at the time of service.**
- Insurance payments not paid in full in 60 days will become your complete responsibility and must be paid in full.

If we are NOT billing dental insurance

We offer a 5%cash/credit discount for treatment paid in full at the time of service.

Payment options

- Your estimated patient portion is due at the time of service. For your convenience we accept Visa, Mastercard, Check, Money Orders or Cash.

OR

- You may pay in full for your treatment, and we will have your insurance reimburse you.

Consent to Pay

I authorize Oswego Dental Specialists to keep my signature on file and to charge my Credit Card account for balance of charges not paid by insurance company within 60 days of claim filing.

Patient Cardholder Name_____

Billing Address_____

Account Number_____

Exp. Date_____ CVC code_____

Signature_____Date_____

Oswego Dental Specialists
Cancellation, Failed and No-Show Appointment Policy

We appreciate you and understand your time is valuable which is why we make every effort to keep you from waiting. As a result, your appointment time in this office is reserved exclusively for you. We reserve the right to charge patients who do not cancel with adequate notice or who fail to keep their scheduled appointments. To respect the needs of all patients, if it is necessary to cancel your reserved appointment, **we require that you contact our office 48 hours in advance.** Appointments are in high demand and your early cancellation will give another patient the opportunity to access timely dental care.

A cancelled, failed or no-show appointment occurs when a patient misses an appointment without cancelling 48 hours in advance. Missed appointments are an inconvenience to patients who need access to dental care in a timely manner and are inconsiderate to our doctor and team who reserve appointment times exclusively for you.

Failed, cancelled and no-show appointments will result in a fee of **$50/half hour of appointed time**. These fees are not covered by insurance and are the sole responsibility of the patient. Fees will be charged to the credit card on file.

We understand that extreme/unavoidable emergencies or circumstances do arise which may require you to cancel your appointment, and individual circumstances will be taken into consideration. Our practice firmly believes that a good physician/patient relationship is based on trust and good communication.

By signing below, I acknowledge receipt of Oswego Dental Specialists' Cancellation, Failed and No-Show Appointment Policy.

Print Name:_____

Signature:_____Date:_____

Credit Card Number:_____

Expiration Date:_____ CVC:_____

Name as it appears on Card:_____