



Welcome to Feathertouch!

About You...

Date \_\_\_\_\_ File # \_\_\_\_\_

Patient Name \_\_\_\_\_ Name you prefer to be called \_\_\_\_\_
Last First MI

Birthdate \_\_\_\_\_ age \_\_\_\_\_ Male Female SS# \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Email \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Minor Single Married Divorced Separated Partner Spouse's Name \_\_\_\_\_

Do you have children? Yes No How Many \_\_\_\_\_

Account Information...

Person Responsible for Account

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Billing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ SS# \_\_\_\_\_ Driver's License# \_\_\_\_\_

Work Phone \_\_\_\_\_

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid for by my insurance company(if offered at this office).

Initial \_\_\_\_\_

## Insurance Information...

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### Primary Dental Insurance

Co. Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Insured's SS # \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Birthdate \_\_\_\_\_ Insured's Employer \_\_\_\_\_

As a courtesy to our patients, we will be happy to file your insurance for you. At time of treatment, you'll be responsible for paying your deductible and/or co-payment. Insurance coverage is estimated — your actual coverage may be less. You, the patient, are responsible for all amounts not covered by your insurance carrier, regardless of reason. Any balance not paid by your insurance company within 45 days is due and is to be paid by you.

Initial \_\_\_\_\_

## In Case of Emergency...

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Who should we contact? \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Who is your Medical Doctor? \_\_\_\_\_ MD's Phone \_\_\_\_\_

## Authorized Family member...

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I \_\_\_\_\_, direct my health care and medical services providers and payers to disclose and release my protected health information to:

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Contact information (Phone number/email): \_\_\_\_\_

Initial \_\_\_\_\_

# DENTAL HISTORY

Patient Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_  
 Referred by \_\_\_\_\_ How would you rate the condition of your mouth?  Excellent  Good  Fair  Poor  
 Previous Dentist \_\_\_\_\_ How long have you been a patient? \_\_\_\_\_ Months/Years  
 Date of most recent dental exam \_\_\_/\_\_\_/\_\_\_ Date of most recent x-rays \_\_\_/\_\_\_/\_\_\_  
 Date of most recent treatment (other than a cleaning) \_\_\_/\_\_\_/\_\_\_  
 I routinely see my dentist every  3 mo.  4 mo.  6 mo.  12 mo.  Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? \_\_\_\_\_

## PLEASE ANSWER YES OR NO TO THE FOLLOWING:

### PERSONAL HISTORY

YES NO

- Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [ ] \_\_\_\_\_
- Have you had an unfavorable dental experience? \_\_\_\_\_
- Have you ever had complications from past dental treatment? \_\_\_\_\_
- Have you ever had trouble getting numb or had any reactions to local anesthetic? \_\_\_\_\_
- Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? \_\_\_\_\_
- Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma? \_\_\_\_\_

### GUM AND BONE

YES NO

- Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing? \_\_\_\_\_
- Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth? \_\_\_\_\_
- Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums? \_\_\_\_\_
- Is there anyone with a history of periodontal disease in your family? \_\_\_\_\_
- Have you ever experienced gum recession, or can you see more of the roots of your teeth? \_\_\_\_\_
- Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing? \_\_\_\_\_
- Have you experienced a burning, painful sensation, or metallic taste in your mouth? \_\_\_\_\_

### TOOTH STRUCTURE

YES NO

- Have you had any cavities within the past 3 years? \_\_\_\_\_
- Does the amount of saliva in your mouth seem too little, not enough, or do you have difficulty swallowing or chewing any food? \_\_\_\_\_
- Do you feel or notice any holes (i.e., pitting, craters) on the biting surface of your teeth? \_\_\_\_\_
- Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? \_\_\_\_\_
- Do you have grooves or notches on your teeth near the gum line? \_\_\_\_\_
- Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? \_\_\_\_\_
- Do you frequently get food caught between any teeth? \_\_\_\_\_

### BITE AND JAW JOINT

YES NO

- Does your jaw joint ever have pain, sounds (clicking, crackling, or popping), or experience limited opening or locking? \_\_\_\_\_
- Do you feel like you need to pull your lower jaw back, or feel that it is being pushed back when you try to bite your back teeth together? \_\_\_\_\_
- Do you avoid or have difficulty chewing gum, raw carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? \_\_\_\_\_
- In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? \_\_\_\_\_
- Are your teeth becoming more crooked, crowded, or overlapped? \_\_\_\_\_
- Are your teeth developing spaces or becoming more loose? \_\_\_\_\_
- Do you have more than one bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together better? \_\_\_\_\_
- Do you place your tongue between your teeth or close your teeth against your tongue? \_\_\_\_\_
- Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? \_\_\_\_\_
- Do you clench or grind your teeth together in the daytime / nighttime or ever make them sore? \_\_\_\_\_
- Do you have any problems with sleep (i.e., restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? \_\_\_\_\_
- Do you wear or have you ever worn a bite appliance? \_\_\_\_\_

### SMILE CHARACTERISTICS

YES NO

- Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (color, spaces, size, shape, display)? \_\_\_\_\_
- Have you ever bleached (whitened) your teeth? \_\_\_\_\_
- Have you felt uncomfortable or self-conscious about the appearance of your teeth? \_\_\_\_\_
- Have you been disappointed with the appearance of previous dental work? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

# MEDICAL HISTORY

Patient Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_

Name of Physician/and their specialty \_\_\_\_\_

Most recent physical examination \_\_\_\_\_ Purpose \_\_\_\_\_

What is your estimate of your general health?  Excellent  Good  Fair  Poor

## DO YOU HAVE or HAVE YOU EVER HAD:

	YES	NO		YES	NO
1. hospitalization for illness or injury _____	<input type="checkbox"/>	<input type="checkbox"/>	26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g., bisphosphonates) _____	<input type="checkbox"/>	<input type="checkbox"/>
2. an allergic or bad reaction to any of the following:	<input type="checkbox"/>	<input type="checkbox"/>	27. arthritis or gout _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine _____			28. autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> penicillin _____			29. glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin _____			30. contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline _____			31. head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> sulfa _____			32. epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> local anesthetic _____			33. neurologic disorders (e.g., Alzheimer's disease, dementia, prion disease) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride _____			34. viral infections (e.g., cold sores) bacterial infections (e.g., Lyme disease) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> chlorhexidine (CHX) _____			35. any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> iodine _____			36. hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> metals (nickel, gold, silver, _____)			37. STI/STD/HPV _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> latex _____			38. hepatitis (type _____) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> nuts _____			39. HIV/AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fruit _____			40. tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> milk _____			41. radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> red dye _____			42. chemotherapy, immunosuppressive medication _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> other _____			43. difficulties with stress management _____	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems, or cardiac stent within the last six months _____	<input type="checkbox"/>	<input type="checkbox"/>	44. psychiatric treatment, antidepressants, mood stabilizing medications _____	<input type="checkbox"/>	<input type="checkbox"/>
4. history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	45. concentration problems or ADD/ADHD _____	<input type="checkbox"/>	<input type="checkbox"/>
5. artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>	<input type="checkbox"/>	46. alcohol/recreational drug use _____	<input type="checkbox"/>	<input type="checkbox"/>
6. pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>			
7. orthopedic or soft tissue implant (e.g., joint replacement, breast implant) _____	<input type="checkbox"/>	<input type="checkbox"/>			
8. heart murmur, rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>			
9. high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>			
10. a stroke (taking blood thinners) _____	<input type="checkbox"/>	<input type="checkbox"/>			
11. anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>			
12. prolonged bleeding due to a slight cut (or INR > 3.5) _____	<input type="checkbox"/>	<input type="checkbox"/>			
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>			
14. chronic ear infections, tuberculosis, measles, chicken pox _____	<input type="checkbox"/>	<input type="checkbox"/>			
15. breathing problems (e.g., asthma, nasal breathing, stuffy nose, sinus congestion) _____	<input type="checkbox"/>	<input type="checkbox"/>			
16. sleep problems (e.g., sleep apnea, snoring, insomnia, restless sleep, bedwetting) _____	<input type="checkbox"/>	<input type="checkbox"/>			
17. kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>			
18. liver disease or jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>			
19. vertigo (e.g., "the room is spinning") _____	<input type="checkbox"/>	<input type="checkbox"/>			
20. thyroid, parathyroid disease, or calcium deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>			
21. hormone deficiency or imbalance (e.g., polycystic ovarian syndrome) _____	<input type="checkbox"/>	<input type="checkbox"/>			
22. high cholesterol or taking statin drugs _____	<input type="checkbox"/>	<input type="checkbox"/>			
23. diabetes (HbA1c = _____) _____	<input type="checkbox"/>	<input type="checkbox"/>			
24. stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>			
25. digestive or eating disorders (e.g., gastric reflux, bulimia, anorexia, celiac disease, Crohn's disease, or any inflammatory bowel disease) _____	<input type="checkbox"/>	<input type="checkbox"/>			

## ARE YOU:

47. presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____	<input type="checkbox"/>	<input type="checkbox"/>
49. taking medication for weight management _____	<input type="checkbox"/>	<input type="checkbox"/>
50. taking dietary supplements, vitamins, and/or probiotics _____	<input type="checkbox"/>	<input type="checkbox"/>
51. often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
52. experiencing frequent headaches or chronic pain _____	<input type="checkbox"/>	<input type="checkbox"/>
53. a smoker, smoked previously or other (e.g., smokeless tobacco, vaping, e-cigarettes, and cannabis) _____	<input type="checkbox"/>	<input type="checkbox"/>
54. considered a touchy/sensitive person _____	<input type="checkbox"/>	<input type="checkbox"/>
55. often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
56. taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
57. currently pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
58. diagnosed with a prostate disorder _____	<input type="checkbox"/>	<input type="checkbox"/>

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) \_\_\_\_\_

List all medications, supplements, vitamins, and/or probiotics taken within the last two years.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_



## Financial Policy

Thank you for choosing us as your dental care provider. Please read carefully and sign to acknowledge understanding and agreement. We are committed to providing you with the best dental care available.

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- You can choose from: **CASH, CHECK, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS.**
  - We offer a **CARE CREDIT** payment plan option- ask us for detailed information.
  - **Payment is due in full on the day that treatment is provided. If your bill is being settled by someone else, payment must be obtained at the time of check out.**
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### **PATIENTS WITH INSURANCE**

- Please provide our office with a copy of the front and back of your dental insurance card.
  - As a courtesy, we will file your dental claims with your provided insurance and attempt to answer any questions we can about your insurance, when possible. Please understand that we cannot speak on their behalf. Your insurance contract is an agreement between you, your employer, and your insurance carrier. If the event occurs that your insurance company has not paid (on your behalf), you will be responsible for all balances.
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### **PATIENTS WITHOUT INSURANCE**

- For those patients without insurance coverage, you will be responsible for full payment on the day of treatment. You will be given an estimate and will be able to discuss financial options with our treatment coordinator.
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### **CANCELLATION/ NO SHOW/ AFTER HOURS POLICY**

Our office requires **2 business days'** notice to cancel your appointment in the case of a conflict or emergency. Please be aware of our current office business hours, as they are not in line with banking hours. Our office reserves the right to charge **\$125.00**, for those not giving adequate advance notice.

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### **COLLECTIONS**

- A \$35.00 charge will be added to your account for any returned checks. You are responsible for all financial costs of collecting or attempting to collect any debt owed to your account. This includes all attorneys' fees, interest, and late fees.
- We reserve the right to send your account to collections, should you fail to pay for the services you receive at our office in a timely manner.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_