SEAN M. ALTENBACH, D.M.D., P.L
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NEW PATIENT PAPERWORK

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE STRICTLY CONFIDENTIAL AND WILL BECOME PART OF YOUR DENTAL RECORD.

TODAY'S DATE: _____

Name: **(Please Print):**	☐ Male ☐ Female	**Date of Birth:**	**Social Security #:**

Home #:	**Cell #:**	**Work #:**	**Email:**

Preferred Method of Contact: ☐ Cell ☐ Home ☐ Work ☐ Email	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Address:	**City, State, Zip**:
Occupation:	**Employer:**
Emergency Contact Name: **Relationship to Patient:**	**Emergency Contact Phone:**
How did you hear about our office, specifically?	

MEDICAL HISTORY:

Name of Primary Care Physician:	Primary Care Physician Phone Number: Date of Last Physical:

Have you ever been treated for:

Arthritis?	☐ Yes ☐ No	HIV or AIDS?	☐ Yes ☐ No
Blood Disorders?	☐ Yes ☐ No	Immunosuppression?	☐ Yes ☐ No
Bacterial Endocarditis?	☐ Yes ☐ No	Kidney Disease?	☐ Yes ☐ No
Cancer? If yes, Explain Below:	☐ Yes ☐ No	Liver Disease? If yes, check below: ☐ HEP A ☐ HEP B ☐ HEP C ☐ Other:	☐ Yes ☐ No
Thyroid Problems?	☐ Yes ☐ No	Lung Disease?	☐ Yes ☐ No
Diabetes? If yes: ☐ Type I ☐ Type II	☐ Yes ☐ No	Nervous Disorders? If yes, Explain:	☐ Yes ☐ No
Gastrointestinal Disorders? If yes, what type?	☐ Yes ☐ No	Neurological Disorders? If yes: ☐ Seizures ☐ Dementia ☐ Epilepsy ☐ Other:	☐ Yes ☐ No
Glaucoma?	☐ Yes ☐ No	Sinus/Nose Problems?	☐ Yes ☐ No
Sexually Transmitted Diseases?	☐ Yes ☐ No	Are you subject to prolonged bleeding?	☐ Yes ☐ No
Are you subject to any healing complications?	☐ Yes ☐ No	Are you subject to fainting spells?	☐ Yes ☐ No

Cardiovascular Disease? ☐ Yes ☐ No If yes, check all that apply:

☐ Heart Attack Date: _____ ☐ Stroke Date: _____ ☐ Heart Surgery Date: _____ ☐ Heart Murmur

☐ High Cholesterol ☐ High Blood Pressure ☐ Low Blood Pressure ☐ Congestive Heart Failure ☐ Mitral Valve Prolapse ☐ Pacemaker

Cardiologist Name:

Artificial (prosthetic) heart valve?	**☐ Yes ☐ No**	**Previous infective endocarditis?**	**☐ Yes ☐ No**
Damaged valves in transplanted heart?	**☐ Yes ☐ No**	**Congenital Heart Disease (CHD)?**	**☐ Yes ☐ No**
Has a physician or previous dentist recommended you take antibiotics prior to dental treatment?	**☐ Yes ☐ No**	**Unrepaired, cyanotic CHD?** **Repaired in the last 6 months?** **Repaired CHD with residual defects?**	**☐ Yes ☐ No** **☐ Yes ☐ No** **☐ Yes ☐ No**

Joint Replacement: Have you ever had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ **Yes** ☐ **No**

Have you ever had radiation in the head/neck region? ☐ **Yes** ☐ **No**
If yes, please explain:

Are you taking, scheduled to begin taking, or have ever taken a drug (like Fosamax, Alendronate, Actonel, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's disease? ☐ **Yes** ☐ **No**

Since 2001, were you treated or are you presently scheduled to begin treatment with a drug (like Aredia, Zometia, XGEVA) for bone pain, hypercalcemia, Paget's disease, multiple myeloma, or metastatic cancer? ☐ **Yes** ☐ **No**
If yes, Date:

Do you have any disease, condition, or problem not listed above? ☐ Yes ☐ No
If yes, please explain:

ALLERGIES & MEDICATIONS:

Are you taking hormones (including birth control)? ☐ Yes ☐ No

Are you taking aspirin? ☐ Yes ☐ No
Are you taking Dilantin? ☐ Yes ☐ No

Are you taking thyroid medication? ☐ Yes ☐ No
Are you taking blood thinners? ☐ Yes ☐ No

Are you allergic to any of the following?

Aspirin: ☐ Yes ☐ No	Latex: ☐ Yes ☐ No	Penicillin (or other antibiotics): ☐ Yes ☐ No
Codeine: ☐ Yes ☐ No	Local Anesthetic: ☐ Yes ☐ No	Barbiturates, sedatives, or sleeping pills? ☐ Yes ☐ No
Sulfa Drugs: ☐ Yes ☐ No	Iodine: ☐ Yes ☐ No	Hay fever/Seasonal Allergies? ☐ Yes ☐ No

Other (allergies), not listed above:

PLEASE LIST ANY MEDICATIONS YOU ARE ON (INCLUDING OVER-THE-COUNTER, HERBAL/NATURAL SUPPLEMENTS, ETC.):

DENTAL HISTORY:

Reason for Today's Visit:	When was your last dental visit?
Have you ever had any problems associated with prior dental treatment? ☐ Yes ☐ No If yes, please explain:	What treatment was rendered at your last dental visit?
How often do you brush?	How often do you floss?

Are you unsatisfied with your smile? ☐ Yes ☐ No
If yes, what would you change?

Would you be interested in improving your smile with clear, invisible orthodontics (**Invisalign**)? ☐ Yes ☐ No

Is your mouth sensitive to temperature, pressure, or sweets? ☐ Yes ☐ No
If yes, what area?

Do you clench or grind your teeth during the day/night? ☐ Yes ☐ No	Are you *unsatisfied* with the color of your teeth? ☐ Yes ☐ No
Do you have or have you ever had jaw/facial pain or headaches? ☐ Yes ☐ No	Do your gums bleed when you brush your teeth? ☐ Yes ☐ No
Are you currently experiencing dental pain or discomfort? ☐ Yes ☐ No	Do you use an electric toothbrush? ☐ Yes ☐ No
Have you noticed drifting or looseness of teeth? ☐ Yes ☐ No	Is your mouth dry? ☐ Yes ☐ No
Do you have or have ever been told you have sleep apnea? ☐ Yes ☐ No	Do you snore? ☐ Yes ☐ No

ALCOHOL: Do you drink alcohol? ☐ Yes ☐ No If yes, how frequently?

TOBACCO: Do you use tobacco? ☐ Yes ☐ No If yes: ☐ Cigarettes – packs/day: _____ ☐ Pipes/Cigars ☐ Chewing Tobacco

WOMEN ONLY:

Are you pregnant? ☐ Yes ☐ No If yes, What trimester? ☐ First ☐ Second ☐ Third Are you breastfeeding? ☐ Yes ☐ No

I certify that I have read and understand the above and that the information given on this is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

PATIENT (OR LEGAL GUARDIAN) SIGNATURE: _____ **DATE:** _____

FINANCIAL POLICY

SEAN M. ALTENBACH, D.M.D.

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT:	
Name:	Relationship to Patient:
Address:	
Phone Number :	Social Security #:
DENTAL INSURANCE INFORMATION:	
Primary Insurance Company:	Employer's Name (or Self-Insured):
Subscriber's Name:	Subscriber's DOB:
Subscriber's Address (If different from above):	
Subscriber's Social Security #:	Patient's Relationship to Subscriber:
Subscriber's/Member ID #:	Group #:
Secondary Insurance Company:	Employer's Name (or Self-Insured):
Subscriber's Name:	Subscriber's DOB:
Subscriber's Address (If different from above):	
Subscriber's Social Security #:	Patient's Relationship to Subscriber:
Subscriber's/Member ID #:	Group #:
Authorization: I authorize the release of any information necessary to process my insurance claim(s). I hereby authorize payment to the dentist of the insurance benefits, otherwise payable to me. A copy of your signature at the conclusion of this document is as valid as the original. As a courtesy to you, we will file your insurance and estimate payment. But, please remember, your insurer dictates your coverage—we do not. Any unpaid balance is your responsibility.	

Thank you for choosing our practice for your dental care. In order to avoid any confusion or uncertainty over financial matters, we have established the following Financial Policy. These guidelines will assist you in understanding your financial responsibilities regarding payment and insurance matters. We request that you read, agree to, and sign this Financial Policy ***prior*** to any treatment.

PAYMENTS:

Our practice accepts Cash, Cashier's Checks, Personal Checks Debit Cards, Visa, Master Card, & Discover as methods of payment. For your convenience, we offer other financing options including but not limited to Care Credit. For additional information, please inquire at the front desk.

INSURANCE:

Insurance carriers provide different levels of benefits for different types of dental procedures. Insurance does ***not*** cover cosmetic procedures. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Professional services are rendered and charged to you. As a service to you, our practice will submit insurance claim forms to your carrier for covered services and make every effort to secure payment from them. If applicable, you must sign insurance benefit payments to our practice. You must understand, however, that you are ultimately responsible for your account whether your insurance carrier pays or not.

Additionally, our office is considered "in-network" by some plans and "out-of-network" by others. This may ultimately affect the amount you will have pay out-of-pocket for services received in this office. If you have any questions about deductibles, coinsurances, or benefit levels, please contact your insurance provider directly. If you have any questions about which insurance plans our office participates with, please ask our front desk receptionist(s).

Due to the difficulty of working with dental insurance carriers, many dental offices do not accept insurance consignment. Without insurance consignment, the patient pays for services rendered in full and the patient files their own insurances claims. As a courtesy to you, our office will submit fees to your insurance company for office visits. In order to clarify your out-of-pocket expense, our office can also perform pre-treatment estimates with your insurance company. Please understand that insurance companies use reasonable and customary (UCR) accrues which may or may not coincide with our fees. You will be responsible for your part of the out-of-pocket expense and any amount over reasonable and customary. If your insurance carrier has not paid your account within 60 days, the balance becomes ***your*** responsibility.

MISSED APPOINTMENTS:

Once an appointment has been made, that time is reserved ***specifically*** for you. We reserve the right to charge a fee for all canceled or missed appointment(s) without 24-hours notice.

PRINT NAME: _____

SIGN: _____ DATE _____