

Welcome to our Office

Our goal is to make every visit *pleasant* and *educational*. We strive to teach good oral care that will enable you to have a beautiful smile that lasts a lifetime.

Name: _____
Last First MI Mr. Mrs. Ms. Dr.

I prefer to be called: _____

Home Address: _____
Street City State Zip

Birthdate: ____ / ____ / ____ Social Security Number: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Best way to confirm appointments: _____

Driver's License #: _____ Married / Single / Divorced

Employer _____ Work #: _____

Employer address: _____

Occupation: _____ Is it ok for you to receive calls at work? Yes / No

Other family members seen by us: _____

Whom may we thank for referring you to our office: _____

In Case of Emergency: Friend or Relative, not living with you:

Name: _____ Relation: _____

Address: _____

Phone number: _____

DENTAL INSURANCE INFORMATION

Insurance Company: _____ Phone: _____

Insurance Address: _____

Subscriber Name: _____ Birthdate: _____

SSN: ____ / ____ / ____ ID # _____ Group #: _____

Subscriber employer: _____

Relationship to patient: Self / Spouse / Child / Other

_____ I authorize the use of radiographs and or photographs of my case for presentations and
Initials publications of Thomas M. Knight, DDS.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize Thomas M. Knight to release any information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. **Please be advised that there is a \$50.00 fee for missed appointments and cancellations with less than 24 hours notice.** Your appointment time is reserved just for you. Please be considerate and allow us time to serve other patients by letting us know in advance if you will be unable to keep your appointment. Should you have concerns regarding this policy please feel free to discuss your questions with us.

Signature: _____ Date: _____

ADULT REGISTRATION

Patient Name: _____ Physician Name: _____

**DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?
PLEASE CHECK ALL THAT APPLY.**

HEART PROBLEMS

- _____ Chest Pain
- _____ Shortness of Breath
- _____ Blood Pressure Problems
- _____ Heart Murmur
- _____ Heart Valve Problem
- _____ Rheumatic Fever
- _____ Pacemaker
- _____ Artificial Heart Valve
- _____ Premedication required by physician

BLOOD PROBLEMS

- _____ Abnormal bleeding
- _____ Blood Disease
- _____ Ever required a blood transfusion

ALLERGY PROBLEMS

- _____ Hay fever
- _____ Sinus problems
- _____ Skin rashes
- _____ Taking allergy medication
- _____ Asthma

INTESTINAL PROBLEMS

- _____ Ulcers
- _____ Weight gain or loss
- _____ Special diet
- _____ Constipation / Diarrhea
- _____ Kidney or bladder problems

BONE OR JOINT PROBLEMS

- _____ Joint replacement
- _____ Premedication required by physician

DIABETES

- _____ Urinate more than 6 times per day
- _____ Thirsty or mouth is routinely dry
- _____ Family history of diabetes

OTHER

- _____ Fainting spells, Seizures, or Epilepsy
- _____ Frequent or severe headaches
- _____ Thyroid problems

- _____ Persistent cough or swollen glands
- _____ Tuberculosis
- _____ Cancer or Tumor
- _____ Do you drink alcohol? Yes No
If so how much _____
- _____ Do you Smoke? Yes No
If so how much _____
- _____ History of alcohol or drug abuse
- _____ Hepatitis, jaundice or liver trouble
- _____ HIV positive / AIDS
- _____ Glaucoma
- _____ Do you have any disease, condition or
problem not listed previously, that you
feel we should know about? If so,
please describe: _____

**Are you allergic or have you reacted to
any of the following**

- _____ Local anesthetics (Novocain)
- _____ Penicillin or other antibiotics
- _____ Barbiturates or sleeping pills
- _____ Aspirin, Acetaminophen, Ibuprofen
- _____ Codeine, Demerol, or other narcotics
- _____ Reactions to metals
- _____ Latex or rubber dams

Are you taking any medications now?

- _____ Antibiotics
- _____ Boniva, Fosamax, Actonel
- _____ Coumadin, etc. (Anticoagulants)
- _____ High blood pressure medication
- _____ Tranquilizers
- _____ Insulin, Orinase or similar drug
- _____ Aspirin
- _____ Digitalis, Nitroglycerine, etc. (Heart meds)
- _____ Cortisone (Steroids)
- _____ Other _____

WOMEN

- _____ Are you taking Contraceptives or hormones
- _____ Are you pregnant? Yes No
If so expected delivery date: _____
- _____ Are you nursing?

HEALTH HISTORY

Patient/Guardian Signature _____ Date: _____

*****For office use only*****

Blood Pressure: _____ / _____

Medical Form Annual Renewal:

Pulse: _____

Patient Initial & Date: _____

Dr. Initials & Date: _____

Date: _____

_____/_____/_____

_____/_____/_____

_____/_____/_____

_____/_____/_____

_____/_____/_____

_____/_____/_____

Patient Name: _____

At *Bainbridge Dental Care*, we can deliver all of your routine dental needs as well as any cosmetic or aesthetic procedures you may be interested in. With flexible payment plans as well as phasing treatment over time, you and your family can achieve spectacular long term results.

Thank you for the opportunity to be of service!

Do you have a specific dental problem? Yes No

Describe: _____

Have you ever had a bad experience in a dental office? Yes No

Describe: _____

Do your gums bleed? Yes No

Does food catch between your teeth? Yes No

Do you floss on a regular basis? Yes No

____ Daily ____ Weekly ____ Monthly ____ When I eat ribs

Do you clench or grind your teeth? Yes No

Do your jaws ever feel tired? Yes No

Do you have popping or clicking in your jaw? Yes No

Have you ever had braces? Yes No

How often do you normally have your teeth cleaned? _____

When did you last have your teeth cleaned? _____

Are you teeth sensitive to:

Cold foods or liquids?	1	2	3	4	5	6	7	8	9	10
Hot foods or liquids?	1	2	3	4	5	6	7	8	9	10
Chewing or pressure?	1	2	3	4	5	6	7	8	9	10
Sweets?	1	2	3	4	5	6	7	8	9	10
	<i>Not at all</i>									<i>Very</i>

Is there anything you would like to change about your smile?

Spacing	Chipped Teeth	Replace Ugly Crowns
Crowing	Discolored Fillings	Replace Silver Fillings

Are you interested in ***Easily*** brightening your smile? Yes No

How nervous are you about having dental care?

1	2	3	4	5	6	7	8	9	10
<i>No Problem</i>									<i>Petrified</i>

Is there anything else we should know about you in order to make your visits with us as pleasant as possible? _____

Bainbridge Dental Care

Thomas M. Knight, D.D.S.

Fees & Payment Policy

In an effort to keep dental costs down while maintaining a high level of professional care, payment is expected at the time of service. We have established the following payment options for our patients.

1. Payment in full at time of treatment will receive a 5% discount for cash or check.
2. In office 3-month budget payment plan – For treatment over \$500.00 (for established patients).
This includes a pre-arranged date for automatic credit card or debit card processing (we will keep your card number on file). In the event that the credit card is declined the remaining balance will be due within 30 days.
3. Long term financing – We are enrolled with Care Credit, and have 3, 6 or 12 month no interest plans available (24 & 48 month plans available at various interest rates). Please ask us if you would like more information. Or you can go to www.carecredit.com.

Treatment plans and cost estimates are available upon request. Please remember we bill your dental insurance as a courtesy, it is not a substitute for payment. We will verify your dental benefits and give you an *estimate* for your portion for all services. Any difference after insurance payment is received will be billed or credited to your account.

For your convenience we accept cash, local checks, Visa & Mastercard.

There will be a \$ 25.00 charge on all checks returned for insufficient funds.
All accounts over 90 days will incur a 1.5% monthly finance charge.

I have read and understand the above Payment policy and agree to its terms.

Date: _____ Signature: _____