SOLARIS
Dentistry

Welcome to our office! We appreciate the confidence you place with us to provide dental services.
To assist in serving you, please complete the following form:

Patient Information

○ Mr. ○ Ms. ○ Mrs. ○ Dr. ○ Married ○ Single ○ Divorced ○ Child / Minor ○ Other:_____ ○ F ○ M

Name _____ NickName: _____
Last Middle First

Address _____
Number Street City State Zip

Home _____ Work _____ Cell _____

Birthday: _____ / _____ / _____ Social Security # _____ E-mail # _____@_____

Employer:_____

If Minor: Parent / Guardian Names: _____ E-mail # _____@_____

_____ E-mail # _____@_____

Emergency contact (not living in household)_____ Phone #_____

How did you hear of our office? ○ Newspaper ○ Website ○ Drive-by ○ Money Mailer ○ Val-Pak ○ Savvy Shopper ○ Ins. Co. ○ Health Fair: _____ ○ Referred By: _____

Dental Insurance Information ○ None

Primary Insurance _____ Insurance Phone Number _____

Group Number_____ Insurance ID#_____

Policyholder _____ Insured's DOB _____ Social Security Number_____
(if different than above)

Employer Name _____ Phone Number _____

Address _____
Number Street City State Zip

Secondary Dental Insurance? ○ Yes ○ No Dental Ins. Co: _____

Subscriber: _____ DOB: _____

Consent for Services *(Please initial each line)*

_____ I authorize Solaris Dentistry to take x-rays, study models, photographs, or any other diagnostic aids deemed necessary. I also authorize Dr. McWilliams to prescribe any and all forms of medications & perform any Dental Treatment that may be indicated and agreed upon either verbal or written.

_____ I grant my permission to you or your assignee, to telephone me at home, work, or cell phone to discuss matters related to this form, and leave messages pertaining to my dental appointments and/or treatment.

_____ I understand there will be no fee charged if more than a 48 hr notice is given to cancel/change my appointment.
If less than 48 hrs is given, I understand there may be a $35 charge for every hour of time that was scheduled.

_____ I am aware that Solaris Dentistry follows protocol of HIPPAA's notice to privacy laws.

_____ I consent to receiving electronic notification of my appointments via e-mail and/or text messaging. I will need to opt out, if I do not want to participate in electronic notifications and messages.

Signature of Patient or Guardian _____ **Date** _____

Patient _____ Date _____

Health History

Date of last physical exam_____

Have you been hospitalized in the last 5 years? ☐ Yes ☐ No
If yes , please describe _____

Are you currently under a physician's care for a particular problem? ☐ Yes ☐ No
If yes to question above, please describe nature of care _____

Name and phone numbers of the physicians who are currently providing you care: _____
_____

*Your answers are for our records and will be confidential. Please **circle** for any questions that have answers Y or N.*

Heart murmur (mitral valve prolapsed)	**Y**	**N**	**Stomach Ulcer or Colitis**	**Y**	**N**
Anemia or any bleeding disorder	**Y**	**N**	**Heart valve**	**Y**	**N**
Abnormal bleeding from cuts	**Y**	**N**	**Pacemaker**	**Y**	**N**
Diabetes	**Y**	**N**	**Psychosis**	**Y**	**N**
Epilepsy or seizures	**Y**	**N**	**Previous biopsies**	**Y**	**N**
Fainting, dizziness or migraines	**Y**	**N**	**Cancer**	**Y**	**N**
Liver disease (Jaundice, Hepatitis)	**Y**	**N**	**Sore/enlarged lymph nodes**	**Y**	**N**
Rheumatic fever	**Y**	**N**	**Radiation therapy**	**Y**	**N**
Shortness of breath or chest pain	**Y**	**N**	**Slow-healing mouth sores**	**Y**	**N**
Emphysema, Asthma, bronchitis, chronic cough	**Y**	**N**	**Other Infections**	**Y**	**N**
HIV Positive or AIDS Related Complex	**Y**	**N**	**Recurrent Infections**	**Y**	**N**
Emphysema or other respiratory Illness	**Y**	**N**	**Joint Replacement**	**Y**	**N**
Abnormal Heart Condition/murmur	**Y**	**N**	**Glaucoma**	**Y**	**N**
Kidney Disease	**Y**	**N**	**Arthritis**	**Y**	**N**
Heart (surgery, disease, stroke, attack)	**Y**	**N**	**Unintentional weight loss/gain**	**Y**	**N**
Venereal Disease	**Y**	**N**	**Latex sensitivity**	**Y**	**N**
Thyroid Disease (Goiter)	**Y**	**N**	**Sinus trouble**	**Y**	**N**

Are you currently taking any of the following:

Antibiotics	**Y**	**N**	**Pre-medication before dental treatment**	**Y**	**N**
Anticoagulants	**Y**	**N**	**Antacids**	**Y**	**N**
Insulin or Oral Anti-diabetic drugs	**Y**	**N**	**Tagamet**	**Y**	**N**
Bisphosphonates(Fosamax, Boniva, Aredia, Actonel,etc)	**Y**	**N**	**Grapefruit juice or extract**	**Y**	**N**

List ALL medications you are currently taking, including prescription or over-the-counter, herbal, vitamins or minerals:

_____ _____
_____ _____
_____ _____

Are you allergic or have you had a reaction to:

Penicillin or other antibiotics	**Y**	**N**	**Codeine, valium or other sedatives**	**Y**	**N**
Aspirin or Ibuprofen	**Y**	**N**	**Other**	**Y**	**N**

Do you smoke or chew Tobacco? ○ Yes ○ No *How much per day?*_____

Any serious problems associated with any previous dental treatment? ○ Yes ○ No

_____

For Women Only:
Are you pregnant, or is there any chance you might be pregnant? ○ Yes ○ No Are you nursing? ○ Yes ○ No
Are you taking birth control pills? ○ Yes ○ No
Are you aware that antibiotics can reduce the effectiveness of birth control pills? ○ Yes ○ No

Signature of Patient or Guardian _____ **Date** _____

Dental Evaluation

Please fill in blanks and CIRCLE all Yes or No questions. Please elaborate if asked…

Name _____ Date _____

Last dental visit _____ last full-mouth x-rays _____last complete dental exam _____
Please describe the main reason for your visit today _____

Are you presently in any dental pain? Yes No
Any unfavorable reaction to dentistry? Yes No Details: _____
Any history of orthodontic treatment? Yes No If YES, When and Where?_____
Any sore, growth, or swelling in your mouth or difficulty in swallowing? Yes No
Do your gums bleed when brushing your mouth? Yes No Do you have a "taste" or odor in your mouth? Yes N
Any history of periodontal disease? Yes No
Is any part of your mouth sensitive to temperature, pressure,or sweets? Yes No Where? _____
Have you ever had a bad reaction to a dental anesthetic? Yes No When / Details?_____
Does food catch between your teeth? Yes No
Are you aware of clenching your teeth during your daytime hours? Yes No _____
Have you ever been told you grind your teeth during sleep? Yes No _____
Are you aware of your jaw clicking or popping while eating or yawning? Yes No _____
Do you have difficulty in opening your mouth widely? Yes No _____
Do you have any "tension" headaches? How often? Yes No _____
Do you wear a night guard? Yes No

Getting to know you (optional)

Are you dissatisfied with your teeth and/or their appearance? Yes No
If yes, what concerns do you have? _____

Are your teeth in alignment?(straight) Yes No
If not, would you be interested in correcting this? Yes No

Do you have spaces between your teeth? Yes No
If so, would you be interested in eliminating them? Yes No

Do you like the color of your teeth? Yes No
If not, do you wish to whiten your teeth? Yes No

Do you like the shape of your teeth? Yes No
If not, would you be interested in changing their shape? Yes No

Do you have a "gummy smile"? Yes No
If yes, would you be interested in discussing solutions? Yes No

Do you like the length of your teeth? Yes No
If not, would you be interested in changing them? Yes No

Are there silver fillings or crowns that you are not happy with? Yes No
If yes, would you be interested in replacing them? Yes No

Would you like to change your smile? Yes No
How would you like your teeth to look? _____

_____

SOLARIS
Dentistry

Financial Policy

We are committed to providing you with the best possible dental care. Our fees reflect our professional commitment and excellence. Please carefully read and sign the following statement of our financial policy prior to treatment.

Our policy is to request payment in full at the time of your treatment. You are responsible for the fees pertaining to your procedure. We have several methods of payment available, and we will be happy to discuss every procedure and fee before we start. All aesthetic services and major treatments require financial arrangements made with a member of our front office staff prior to making your appointments. In some cases, we may require a credit or debit card be presented prior to rendering services.

For patients with dental insurance, we are happy to help you receive your maximum allowable benefits. We ask that you **read your policy to be sure that you are fully aware of any limitations of the benefits provided.** We accept payment directly from the PRIMARY and SECONDARY insurance company for that percentage (%) your insurance will cover; **however we require that the deductible and estimated non-covered fees from your Primary and Secondary be paid at each visit**. We are NOT able to submit to more than TWO dental insurance companies. In other words, you will be responsible for all co-pay, coinsurance, and deductibles on the day of service. **You are ultimately responsible for payment of services rendered.** Please be aware that any parent bringing a child to our office is legally responsible for payment of all services in according with the same payment arrangements stated above.

Please realize that your dental benefit program is a contract between you, your employer and the insurance company. We are not a party to that contract. This office files your insurance as a courtesy to you. Not all dental services are covered benefits in all contracts. For patients who have insurance, an **estimate** of the benefits of your insurance plan will be discussed prior to treatment. Please know that a secondary insurance does not necessarily mean that your entire treatment will be covered due to your individual policy limits. ASK your insurance company HOW they pay as a secondary. For Example: NON-duplication = you will have co-pays.

Delinquent accounts will be turned over to a collection agency and/or small claims court. By signing below, you agree to pay all finance charges, collection costs, attorneys fees, and any other cost that may be incurred to enforce collection of any amount outstanding.

For your convenience, **we accept Visa, MasterCard, Discover, or cash**. **We do not accept AMEX or Checks**. We also work closely with Spring Stone Patient Financing to offer you a choice to finance your treatment, should you decide to do so. We will be happy to assist you in completing an application. Credit approval is required. Our financial coordinator can help you in formulating a financial plan to meet your needs **before your treatment is scheduled**.

_____ **I understand a $35/hr Fee will be applied to my account if I do not provide the office 48 hour notice of any changes needed to my scheduled appointment.** To avoid a $35.00/hr. fee, we require 48 business hours (Mon-Thurs). We prefer NOT to charge you this fee, HOWEVER your appointment time scheduled has been reserved for specifically for you and is dedicated one-on-one time with our dentist. We DO NOT overbook, double book, etc.

Our business office is available to help you with any questions you may have. Thank you for choosing our office to meet your dental needs. Please let us know if there is anything we can do to make your visit a pleasant one.

I have read and I understand the Financial Policy and Notice of Privacy Practices and I agree to abide by its terms. I have disclosed all information regarding my health history, medications I am on, and any known allergies to medications.

_____ _____

(Patient or Guardian's Printed Name) (Today's Date)