

Welcome to
TOWNE SQUARE DENTAL
Dr. Wade Pilling & Dr. Jordan Pilling

Patient Information:

Patient Name: _____
Last First Preferred Name

Date of Birth: _____ Social Security Number: _____

Address: _____
Street City State Zip

Home Phone: _____ Cell: _____ Work: _____
(Please list all contact numbers, there may be times when we need to get a hold of you on short notice.)

Email Address: _____ Employer: _____

Spouse's Name: _____ DOB: _____ SSN: _____

Spouse's Employer: _____ Spouse's Work Number: _____

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

Responsible Party:

Self: _____ Other: _____
Last First Middle

If "Other" please complete:

Address: _____
Street City State Zip

Home Phone: _____ Cell: _____ Work: _____

If you have Dental Coverage, please fill out:

Subscriber Name: _____ DOB: _____ SSN: _____

Insurance Carrier: _____ Employer: _____

Group #: _____ Insurance Phone Number: _____

Emergency Contact Information:

Name of your emergency contact: _____ Phone Number: _____

Financial Policy:

At Towne Square Dental it is our mission to provide the best possible dental care for our patients. In an effort to keep our fees affordable, payments is due at the time of service unless prior arrangements have been made. We accept cash, check, debit, Visa and MasterCard. For patients with dental insurance, we will gladly accept assignment of your insurance benefits if you provide us with accurate information. We make ever effort to closely estimate for you what your insurance coverage will be for your treatment. However, there are times when insurance under pays or denies payment on a claim for a variety of reasons. Any remaining balance not paid by insurance within 60 days will become the responsibility of the patient or the patient's guardian if the patient is a minor. Your signature bellows indicates that you have read, understand and agree to this policy.

Patient's Signature: _____ Date: _____
(Or Guardian if patient is a minor)

Patient Medical History:

- Have there been any changes in your general health within the past year? YES/NO
If so, what conditions are being treated? _____
Physician's Name: _____ Phone #: _____

- Have you ever been hospitalized or had a serious operation or illness within the past 5 years? YES/NO
If so, what condition was treated? _____

- Do you have or have you had any of the following diseases or problems? Please check:

- | | | |
|---|---|--|
| <input type="checkbox"/> Drug Use/Abuse | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> cardiac pacemaker | <input type="checkbox"/> Easily Winded |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Angina | <input type="checkbox"/> Hay fever/Allergies |
| <input type="checkbox"/> Fainting/Seizures | <input type="checkbox"/> Frequently Tired | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Chest pains |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Cancer | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Implant | <input type="checkbox"/> Heart trouble |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> AIDS of HIV | <input type="checkbox"/> STD | <input type="checkbox"/> Mitral valve Prolapse |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Stomach trouble/Ulcers | <input type="checkbox"/> Other _____ |

- Are you taking any drugs, medicine or herbal supplements? YES/NO
If so, what _____

- Are you allergic or have you reacted adversely to any of the following:

- | | | | | |
|--|---------------------------------------|------------------------------------|----------------------------------|--------------------------------|
| <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Metal | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Penicillin or other Antibiotics | <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Sedatives | <input type="checkbox"/> Iodine | |
| <input type="checkbox"/> Other _____ | | | | |

FOR WOMEN ONLY:

- Are you pregnant or breast feeding? YES/NO
If yes, what month? _____ Are you taking birth control? _____

Patient Dental History:

- What's your chief complaint _____
- Name of previous Dentist _____
- Date of last exam _____ Date of last dental x-rays _____
- Do your gums bleed while you brush or floss? YES/NO
- Are your teeth sensitive to hot or cold liquids or foods? YES/NO
- Are you teeth sensitive to sweet or sour liquids or foods? YES/NO
- Do you feel any pain in your teeth? YES/NO
- Do you have any lumps or sores in your mouth? YES/NO
- Have you ever experienced any of the following problems with your jaw: clicking, pain (joint, ear, side of face) difficulty opening or closing or difficulty chewing? _____
- Do you have frequent headaches? YES/NO
- Do you clench or grind your teeth? YES/NO
- Do you bite your lips or cheeks frequency? YES/NO
- Have you had orthodontic treatment before? YES/NO
- Do you wear dentures or partials? YES/NO
- Have you had any serious trouble associated with any previous treatment? YES/NO
- Have you had abnormal bleeding associated with previous extractions, surgery or trauma? YES/NO
- Is there anything about your smile that you don't like such as discolored teeth, crooked teeth, broken teeth, unsightly silver fillings, or bad breathe? _____

CONSENT: The undersigned hereby authorized the dentist of Towne Square Dental to take radiographs. Photographs or any other diagnostic aids deemed appropriate by the dentist to make thorough diagnosis of the patient's dental needs. I also understand the use of anesthetic agents embodies a certain risk. I authorize Towne Square Dental to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or healthcare practitioners. I acknowledge I have had the opportunity to read the Towne Square Dental Notice of Privacy Practices and a copy was available to me.

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(Or Guardian if patient is a minor)

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PAYMENT OPTIONS

Towne Square Dental strives to offer convenient payment options, while at the same time maintaining the high standard of comprehensive dental care that our patient's deserve. At the onset of your treatment, we will provide you with an estimate of your treatment cost. Our goal is to help you afford your dental choices.

Please understand that this will only be an "estimate". Should the need for additional treatment arise during the course of the original treatment plan, the fees could change. Be assured that we will make effort to notify you of fee changes and obtain your approval prior to proceeding with treatment. Please take a moment to review the financial options offered and indicate your choice of payment.

PAYMENT OPTIONS

Payment is due in full on the day of each visit. You may use your credit or debit card for services rendered. We gladly accept cash, check and/or Visa and Master Card.

For our patient's who want to make monthly payments, we offer a short and long term financing through Care Credit, Citi Health Card and/or Capitol One. With Care Credit, Citi Health Card and/or Capitol One, we offer up to twelve (12) months interest free. A staff member will gladly assist you with the application process.

Our goal is to help you maximize your dental insurance benefits. As a courtesy, we are happy to bill your dental plan services. Please remember that your contract itemizing your dental benefits is between you, your employer and your insurance carrier. Regardless of coverage, your estimated co-payment is due in full the day of treatment, unless prior arrangements have been made. If your dental plan doesn't pay within sixty (60) days of treatment, you must pay any outstanding balance and seek reimbursement from your dental plan. If your dental insurance pays more than expected, you will receive a prompt refund check from Towne Square Dental. Also remember that dental insurance plans are not designed to cover all your needs. Rather, the amount your dental plan contributes towards your dental care is based on the plan you purchases by your employer.

Again, feel free to ask any member of our staff if you have any questions regarding the payment options described above. We thank you fro trusting us with your dental care needs, and hope that you will let us know if we can improve our services to you in any way.

I accept full responsibility for this account and for all dentistry performed upon my dependents in this dental office. I understand that this office cannot guarantee my insurance eligibility, waiting periods and/or benefits. **I have read and understand my obligations and I acknowledge that I am fully responsible for payment of any service not covered or underpaid by my insurance carrier.**

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<i>BROKEN APPOINTMENT POLICY</i>

Reserved appointment time in any dental office is limited and valuable.

It is extremely important that all patients honor their reserved dental appointments. Failure to do so deprives our other patients from receiving needed dental care in a timely fashion.

So that the dentist, our staff, and our patients will not be penalized by those who fail to keep an scheduled appointment, our office policy stipulated that failure to give sufficient warning to keep a scheduled appointment, (**24 hours advanced notification**), will result in a ***\$40.00 fee/hour you were scheduled*** being charged. This charge which is in accordance with our dental office's broken appointment policy is for **all** of our patient's and is to be paid prior to scheduling of any new appointment. The patient is responsible for payment of charge.

For ALL Medicaid patient's, If you break one or more appointments without sufficient notice, we reserve the right to report you to the Medicaid benefits program which will result in the loss of benefits.

Please feel free to discuss this and other policies with our staff.

Patient's Signature: _____ Date: _____
(Or Guardian if patient is a minor)