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.

ADULT REGISTRATION

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:** _____

Patient Name:_____ **Physician Name:**_____

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

HEALTH HISTORY

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?

Patient/Guardian Signature_____ Date:_____

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

Blood Pressure: _____/_____
Pulse: _____
Date:_____

Medical Form Annual Renewal:

Patient Initial & Date:	Dr. Initials & 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!

DENTAL HEALTH HISTORY

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
	Not at all									*Very*

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
No Problem									*Petrified*

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:_____