WELCOME

We appreciate your trust and confidence in choosing Plaza Dental Center. We strive to make each of your visits pleasant & comfortable.

PLAZA DENTAL CENTER
4646 Lindell Boulevard
St. Louis, MO 63108
(314) 361-1818

1 ABOUT YOU

Today's Date:_____

Name:_____

I prefer to be called:_____ ☐ Male ☐ Female

Birthdate:___/___/___ SS#:_____

Home Address:_____

City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Email Address:_____

Employer:_____

City State Zip

How long there?_____ Occupation:_____

Other family members seen by us:_____

Email Address:_____

Previous Dentist:_____

Last Visit Date:_____

Spouse Name:_____

Employer:_____

Birthdate:___/___/___ DL#:_____

Person Responsible for Account:_____

Billing Address:_____

Relationship:_____ SS#:_____

Employer:_____ DL#:_____

2 DENTAL INSURANCE

Do you have dental insurance through your employer? ☐ Yes ☐ No
If yes, please provide the following information:

Primary Dental Insurance

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone #:_____

Group# (Plan, Local, or Policy#):_____

Insured's Name:_____ Relation:_____

Insured Birthdate:___/___/___ Insured's SS#:_____

Insured's Employer:_____

Insured's Address:_____

Do you have any other Dental Insurance Coverage? ☐ Yes ☐ No

This coverage is through: ☐ Spouse ☐ Parent ☐ Other

Secondary Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone #:_____

Group# (Plan, Local, or Policy#):_____

Insured's Name:_____ Relation:_____

Insured Birthdate:___/___/___ Insured's SS#:_____

Insured's Employer:_____

Insured's Phone:_____

TELEPHONE

Home Phone:_____ Work Phone:_____

Pager or car phone:_____ When is the best time to reach you?_____

Where?_____ Specific days?_____

In the event of an emergency, is there someone who lives near you that we could contact?

His / Her Name:_____ Relation:_____

Wk #:_____ Hm #:_____

3 MEDICAL HISTORY

Do you have a personal physician? Y N
Physician's Name: _____
Phone #: _____
Date of last visit: _____

Your current physical health is: Good Fair Poor
Are you currently under the care of a physician? Yes No
Please explain: _____
Do you smoke or use tobacco in any other form? Yes No
Are you taking any prescription / over-the-counter drugs? Y N
Please list each one: _____
_____

For Women: Are you taking birth control pills? Yes No
Are you pregnant? Yes No Week #: _____
Are you nursing? Yes No

Have you ever had any of the following:

Y N Anemia / Radiation Treatment
Y N Artificial Bones / Joints
Y N Artificial Valves
Y N Asthma / Arthritis
Y N Blood Transfusion
Y N Cancer / Chemotherapy
Y N Congenital Heart Defect
Y N Diabetes / Tuberculosis (TB)
Y N Difficulty Breathing
Y N Drug / Alcohol Abuse
Y N Emphysema / Glaucoma
Y N Epilepsy / Seizures / Fainting Spells
Y N Fever Blisters / Herpes
Y N Heart Attack / Stroke
Y N Heart Murmur
Y N Heart Surgery / Pacemaker
Y N Hemophilia / Abnormal Bleeding
Y N Hepatitis
Y N High / Low Blood Pressure
Y N HIV+ / AIDS
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Rheumatic / Scarlet Fever
Y N Severe / Frequent Headaches
Y N Shingles
Y N Sinus Problems
Y N Ulcers / Colitis
Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had:
_____
_____

Are you allergic to any of the following:

Y N Aspirin Y N Erythromycin Y N Tetracycline
Y N Codeine Y N Latex Y N Other
Y N Penicillin Y N Dental Anesthetics

Please list any other drugs that you are allergic to: _____
_____

Medical Release Authorization

I Authorize release of any information necessary to process my dental records.

_____ __/__/__
Signed Patient or Parent in Minor

Payment Of Benefits

I Hereby Authorize payment directly to the dentist of the group insurance benefits otherwise payable to me.

_____ __/__/__
Signed Insured Person

4 DENTAL HISTORY

Your current dental health is:
☐ Good ☐ Fair ☐ Poor

Why have you come to the dentist today?
_____
_____

Are you currently in pain? Yes No

Have you ever had a problem associated with any previous dental work? Yes No

Are your teeth sensitive to heat, cold, or sweets? _____
Have you ever had gum treatment? Yes No
Do your gums ever bleed? Y N
How many times a week do you floss?____a day do you brush?____
Do you like your smile? Y N
Do you cover your mouth when you talk or smile? Y N
Would you like to change anything about your smile? Y N

☐ Shape ☐ Color ☐ Size

5 FOR YOUR INFORMATION

Please read office policy:

Fees will be charged as services are rendered. Payment in full is expected at the time of services, or your estimated insurance co-payment when benefits are assigned to our office.

PATIENTS WITH INSURANCE: We will work with you to get your deserved benefits but you are responsible for payment to this office. For your convenience we estimate to you what we anticipate your insurance to pay. However, it is an estimation and should not be considered by you as your final co-payment / portion. If for any reason your insurance does not pay; what we estimate them to pay, what you estimate them to pay, pay what they pre-determine, or if they cause payment delays more than ninety days after services rendered then the balance is due by you to our office. Our office is not liable for policy limitations, exclusions, or clauses your insurance may impose to restrict / limit payment. The relationship is between you and our office and you and your insurance carrier Not between Plaza Dental Center and the insurance carrier. We expect you to pay for any services not covered by your insurance.

Fixed or Removable Prosthetic, such as dentures, crowns, bridges or partial dentures, are understood to be a product that is uniquely suited to each particular patient. The full fees for such service is, therefore considered to be due and payable when the initial impression is made. Prosthetics must be seated in a timely manner to insure your comfort and proper fit. If you fail to have your prosthetic permanently seated within 30 days from the date of impression, a second impression may need to be taken, and you will be charged an additional amount.

All x-rays taken are a part of our permanent records, there is a duplication charge for any x-rays removed from this office.

A service fee is charged for all returned checks.

If for any reason you fail to pay your balance once billed, we reserve the right to secure a collection agency to collect the debt for us. You will be liable for court cost, attorney fees, and collection agency fees necessary to enforce collection of this debt.

I have read and understand the above policies, and agree to the terms.
Patient signature

_____ Date: _____