sweet tooth dental
A FAMILY DENTAL PRACTICE

Date _____

Patient _____
Last Name First Name
Street Address _____
City _____State _____Zip Code_____
Home Phone (____) _____Cell Phone (___) _____
Social Security # _____ Driver's Lic # _____
Sex: Male _____ Female _____ Age _____ Birth Date _____
Single _____ Married _____ Email: _____
Employer _____Phone # _____
Employer Address _____
In Case of Emergency: (Closest Relative or Friend)
Name:_____ Phone # (__)_____

Medical & Information Update

___/___/___ ____
___/___/___ ____
___/___/___ ____

MEDICAL HISTORY: Do you or have you ever had any of the following? Please check those that apply. *This condition may require antibiotic premedication for certain dental procedures.

❑ Allergies/Hay fever/Sinus	❑ Emphysema	❑ Heart Surgery*	❑ Rheumatism
❑ Anemia	❑ Epilepsy or Seizures	❑ Hepatitis	❑ Shortness of Breath
❑ Angina	❑ Excessive Thirst	❑ High Blood Pressure	❑ Blood Disorder
❑ Arthritis	❑ Fainting or Dizziness	❑ HIV+/AIDS	❑ Sinus Problems
❑ Artificial Joints*	❑ Fever Blisters/Cold Sores	❑ Kidney Problems	❑ Stroke
❑ Artificial Heart Valves*	❑ Frequent Cough	❑ Liver Problems	❑ Surgical Shunt*
❑ Asthma	❑ Glaucoma	❑ Mental Disorders	❑ Thyroid Problems
❑ Cancer	❑ Heart Disorder (Congenital)*	❑ Mitral Valve Prolapse*	❑ Tuberculosis
❑ Chemical Dependency	❑ Heart Infection*	❑ Radiation Treatment	❑ Ulcers
❑ Chemotherapy	❑ Heart Murmur*	❑ Respiratory Problems	❑ STD/HPV
❑ Diabetes	❑ Heart Pace Maker*	❑ Rheumatic Fever*	❑ Yellow Jaundice

Yes	No	
❑	❑	Are you taking aspirin everyday or any anti coagulant (blood thinners)_____
❑	❑	Are you taking any medication for osteoporosis? _____
❑	❑	Do you have any health problems that were not listed above or need further clarification? If yes, explain:_____
❑	❑	Are you now under the care of a physician? If yes, explain:_____
❑	❑	Have you been admitted to a hospital or needed emergency room care during the past two years? If yes, explain: _____
❑	❑	Are you allergic to any medications or substance? Sensitivity to Latex? _____ If yes please list._____
❑	❑	Have you ever had severe bleeding or other complications following an extraction? _____
❑	❑	Are you pregnant or taking birth control pills? **Circle One**
❑	❑	Is there anything else in your medical history of significance? If yes, explain:_____

How long has it been since your last dental visit/cleaning? _____

List all medications prescription or over the counter that you are presently taking.

_____

Do you use Tobacco, Alcohol, or Drugs? (Circle) How frequently? _____

How did you first hear about Sweet Tooth Dental?
☐ Sign ☐ Internet ☐ Newspaper ☐ Phonebook ☐ Doctor ☐ Friend ☐ Other _____
Who may we thank for referring you to our office? _____

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INSURANCE INFORMATION, ASSIGNMENT AND RELEASE

Insured Name _____Birth Date _____
Employer _____Insurance Co _____
SS# or Member ID_____ Group # _____ Phone # _____

I certify that I am / my dependent(s) are covered by insurance with the named insurance company and assign directly to Dr. Gretchen Juncker all insurance benefits, if any, otherwise payable by me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions._____ (Please sign)

All attempts are made to collect the exact amount your insurance company does not cover. Unfortunately, this does not always happen. YOU ARE RESPONSIBLE FOR ANY BALANCE. If you feel this is not acceptable, we will collect your payment in full, file your claim and have your insurance company reimburse you directly.
DO YOU HAVE ANY QUESTIONS REGARDING THIS POLICY? NO or YES _____ (initial)

CANCELLATIONS: For appointments cancelled with less than 48 hours prior notice, there will be a charge of $50.

FINANCIAL AGREEMENT

Who is responsible for this account: _____

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. All accounts that go beyond 60 days past due are automatically transferred to our collection department, and will be reported to the credit bureau. I am responsible for paying any legal interest on the balance due, together with any delinquent fee, postage fee and reasonable attorney fees incurred to effect collection on this amount.
_____ (Initial)

Separated or divorced parents: The individual, who initiates services, is financially responsible for the account. We do not bill the other parent. _____ (Initial)

PRIVACY PRACTICES ACKNOWLEDGEMENT

We want to assure you that your health information is secure with us. If you have any questions regarding our Privacy Policy, please ask any staff member.

The office of Dr. Gretchen Juncker has made available to me the Notice of Privacy Practices and I have been provided an opportunity to review it.

I authorize the office of Dr. Gretchen Juncker to discuss the following information with the named people listed below.

_____Verify appointment _____
_____Discuss account balance _____
_____Discuss insurance _____
_____Discuss dental treatment _____

_____ _____
Signature of Patient, Guardian or Personal Representative Date