TRAPPE FAMILY DENTAL
COSMETIC & GENERAL

Patient: _____

Date : _____

PATIENT INFORMATION

Name: _____ Preferred Name: _____

Birth Date: _____ Social Security Number: _____ Gender: ◯ Male ◯ Female

Address: _____

City: _____ State: _____ ZIP _____

Email: _____ Cell Phone: _____

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Other

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Who may we thank for referring you? _____

Previous Dentist: _____ Date of last exam: _____

INSURANCE INFORMATION

◯ No Dental Insurance

◯ Primary Insurance

Name of Insurance Company: _____ State: _____

Policy Holder Name: _____ Birth Date: _____

Member ID: _____ Group: _____

Name of Employer: _____

Relationship to Insurance holder: ◯ Self ◯ Parent ◯ Child ◯ Spouse ◯ Other _____

INSURANCE INFORMATION

◯ Secondary Insurance

Name of Insurance Company: _____ State: _____

Policy Holder Name: _____ Birth Date: _____

Member ID: _____ Group: _____

Name of Employer: _____

Relationship to Insurance holder: ◯ Self ◯ Parent ◯ Child ◯ Spouse ◯ Other _____

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CONFIDENTIAL HEALTH HISTORY

Physician's Name: _____ Date of last exam: _____

Has your present health changed in the previous year? ◯ Yes ◯ No

If Yes, please explain: _____

Has a physician treated you for any condition in the previous year? ◯ Yes ◯ No

If Yes, please explain: _____

Have you ever been hospitalized for any surgery or serious illness? ◯ Yes ◯ No

If Yes, please explain: _____

MEDICATIONS

Are you currently taking Aspirin/Blood thinners? ◯ Yes ◯ No

Please list any medications you are currently taking:

_____

_____

ALLERGIES

Are you allergic to or have you had an adverse reaction to:

◯ Aspirin ◯ Dental Anesthesia ◯ Penicillin ◯ Sulfa

◯ Household bleach ◯ Latex ◯ Codeine ◯ Iodine

◯ Other (please list): _____

WOMEN

Please check to indicate if any of the following apply:

◯ Pregnant

◯ Nursing Due Date(if pregnant): _____

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OTHER MEDICALLY DIAGNOSED PROBLEMS

Please check to indicate if you have had problems with or are presently complaining of any of the following:

- ◯ Acid reflux
- ◯ ADHD
- ◯ AIDS/HIV
- ◯ Alcohol abuse
- ◯ Anemia
- ◯ Anxiety
- ◯ Arthritis / Rheumatism
- ◯ Artificial heart valves
- ◯ Artifical joints
- ◯ Asthma
- ◯ Autism
- ◯ Autoimmune Disease
- ◯ Bleeding abnormally
- ◯ Blood disease
- ◯ Cancer
- ◯ Chemical dependency
- ◯ Chemotherapy
- ◯ Chronic cough
- ◯ Circulatory problems
- ◯ Congenital heart lesions
- ◯ Cortisone treatments
- ◯ Cystic Fibrosis
- ◯ Diabetes
- ◯ Dental related anxiety
- ◯ Depression
- ◯ Drug abuse
- ◯ Emphysema
- ◯ Epilepsy
- ◯ Extreme weight loss / gain
- ◯ Fainting or dizziness
- ◯ Glaucoma
- ◯ Headaches
- ◯ Heart murmur
- ◯ Heart problems
- ◯ Hepatitis*

  If **Yes**, circle type: A B C
- ◯ Herpes
- ◯ High blood pressure
- ◯ High cholesterol
- ◯ Joint replacement
- ◯ Kidney disease
- ◯ Liver disease
- ◯ Low blood pressure
- ◯ Mitral valve prolapsed
- ◯ Muscular Dystrophy
- ◯ Nausea
- ◯ Osteoporosis/Osteopenia
- ◯ Pacemaker
- ◯ Pneumonia
- ◯ Psychiatric care
- ◯ Radiation treatment
- ◯ Respiratory disease
- ◯ Rheumatic fever
- ◯ Seasonal allergies
- ◯ Shortness of breath
- ◯ Sinus troubles
- ◯ Skin rash / disorders
- ◯ Special diet
- ◯ Stomach Ulcers
- ◯ Stroke
- ◯ Swollen neck glands
- ◯ Thyroid problems
- ◯ Tonsillitis
- ◯ Tuberculosis
- ◯ Tumor or growths
- ◯ Venereal disease
- ◯ Other: _____
- ◯ _____
- ◯ _____
- ◯ _____

ADDITIONAL INFORMATION

Do you have any artifical joints? ◯ Yes ◯ No

If yes, please describe: _____

Do you need to pre-medicate for dental procedures? ◯ Yes ◯ No

Have you ever taken bisphosphonates or bone-building drugs? ◯ Yes ◯ No

Do you have any physical limitations? (wheelchair, walker, mobility) ◯ Yes ◯ No

If yes, please describe: _____

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DENTAL PROBLEMS/HISTORY

Please check any that apply:

- ◯ Bad breath
- ◯ Bleeding gums
- ◯ Burning sensation on tongue
- ◯ Chew on one side of mouth
- ◯ Chewing tobacco use
- ◯ Cigarette/pipe/cigar smoking
- ◯ Clicking or popping jaw
- ◯ Dry mouth
- ◯ Fingernail biting
- ◯ Food collection between teeth
- ◯ Grinding teeth
- ◯ Gums swollen or tender
- ◯ Jaw pain or tiredness
- ◯ Lip or cheek biting
- ◯ Loose teeth or broken fillings
- ◯ Mouth breathing
- ◯ Periodontal treatment
- ◯ Sensitivity to cold
- ◯ Sensitivity to hot
- ◯ Sensitivity to sweets
- ◯ Sensitivity when biting
- ◯ Sores or growths in mouth
- ◯ Vape Use
- ◯ Other: _____

DENTAL HISTORY

How often do you brush your teeth? _____

What texture brush do you use? ◯ Soft ◯ Medium ◯ Hard

Do you use any of the following? ◯ Floss ◯ Mouthwash ◯ WaterPik ◯ Proxy Brush

If yes, how often? _____

Have you ever had any head, neck, or jaw injuries? ◯ Yes ◯ No

If yes, please explain: _____

Are you happy with your smile and teeth? ◯ Yes ◯ No

If no, please explain: _____

Have you every had an upsetting experience in a dental office? ◯ Yes ◯ No

If yes, please explain: _____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I certify that I have read and understood the foregoing questions. To the best of my knowledge, all questions have been answered completely and accurately.
I authorize the dentist to release any information—including diagnoses, treatment records, radiographs, or examination results—to third-party payers and/or healthcare practitioners.

Patient/Guardian Signature: X _____ Date: _____

FINANCIAL POLICY

Trappe Family Dental is committed to providing exceptional dental care to all our patients. In order to achieve this goal, we need your assistance and understanding of our payment policy.

Payment for services is expected at the time the services are provided. If treatment requires multiple visits, payment may be divided among the necessary appointments. To provide our patients with flexible payment options, we accept the following forms of payment. Please select the option that works best for you:

◯ Cash ◯ Check ◯ Visa, Mastercard, Discover, American Express

Returned checks may be subject to additional charges, as are missed appointments and those canceled with less than 48 hours notice.

Trappe Family Dental is a participating provider with select insurance companies. However, as a courtesy to our patients with out-of-network insurance, we are happy to file insurance claims on your behalf.
Please remember that your dental insurance is your responsibility, though we are here to assist. Regardless of our estimate of your dental benefits, we must emphasize that you, the patient, are responsible for the total treatment fee.

As a courtesy, we can accept assignment of benefit payments from most insurance companies. This reduces your immediate out-of-pocket expenses. When direct payment is made to our office by your insurance company, we will estimate your deductible and any portion not covered by insurance. The patient portion (co-pay) is due at the time services are rendered. Our estimates may differ from your insurance company's calculations; therefore, the final amount due will be adjusted once payment is received.

Please remember that your insurance is a contract between you, your employer, and the insurance company. We are not contracted with many insurance providers and, therefore, cannot control what they reimburse for treatment. If you have any questions regarding your coverage or any of the information above, please don't hesitate to contact us. We are here to help!

X _____ _____

Patient/Responsible Party Signature Date

APPOINTMENT CANCELLATION POLICY

At Trappe Family Dental, appointments are scheduled in advance by reserving time slots to accommodate you and your treatment needs. Our team spends time meticulously preparing for each appointment by sterilizing, organizing, and arranging all necessary items prior to your arrival. This ensures that we maintain the high standard of care we pride ourselves on.
Therefore, we require at least 48 hours notice for canceling or rescheduling appointments. Patients who cancel or reschedule without proper notice may be assessed a $75.00 fee to offset the lost production time and the estimated time and effort our staff has already spent preparing for the appointment.

X _____ _____

Patient/Responsible Party Signature Date