ANDREW MINNIGH, DDS

Welcome! We are pleased you have chosen our practice. Please fill out the following form as completely as you can.

Patient Information

Name _____ Social Security # _____
Last Name *First Name* *Initial*

Mailing Address _____
Street *City* *State* *Zip*

Home Phone _____ Cell Phone _____

Sex ❑ M ❑ F Age _____ Birthdate _____ Driver's License # _____

Employer _____ Occupation _____

Work Address _____ Work Phone _____

Whom may we thank for referring you? _____

Notify in an emergency _____ Home Phone _____

Cell Phone _____ Work Phone _____

Email _____

Responsible Party

Person Responsible for Account *(if different from patient)* _____
Last Name *First Name* *Initial*

Relation to Patient _____ Birthdate _____ Social Security # _____

Address *(if different from patient)* _____
Street *City* *State* *Zip*

Home Phone *(if different)* _____ Cell Phone *(if different)* _____

Employer *(if different)* _____ Occupation *(if different)* _____

Primary Dental Insurance

PLEASE PROVIDE YOUR DENTAL INSURANCE CARD(S) TO THE FRONT OFFICE.

Name of Insured _____ Insured's Employer _____

Insurance Provider _____ ID # _____

Relation to Insured ❑ Self ❑ Spouse ❑ Dependent Group # _____

Secondary Insurance

Name of Insured _____ Insured's Employer _____

Insurance Provider _____ ID # _____

Relation to Insured ❑ Self ❑ Spouse ❑ Dependent Group # _____

Payment Arrangements

- **Dr. Minnigh requires payment for his services at the time of treatment.** We gladly accept cash, check, Visa, MasterCard, American Express, Discover, and CareCredit.
- We will **estimate your co-payment** based on the estimation of benefits your insurance company provides us. We will bill your insurance company accordingly, but require that you pay any deductible and co-payment at the time of service.
- **Your insurance company does NOT guarantee payment to Dr. Minnigh, and you are responsible for any remaining balance your insurance does not pay**. Should your dental insurance not pay within 60 days, or if payment is denied, we will send you a statement with the unpaid balance. You may seek reimbursement from your insurance company.
- All procedures involving laboratory expenses (crowns, bridges, dentures, partials) require a retainer of half the estimated fee when the service is started, with the balance paid at the time of placement.

ANDREW MINNIGH, DDS

Dental History

What would you like us to do today? _____ Are you in dental discomfort? ❑ Y ❑ N

Former Dentist _____ Address _____

Phone _____ Date of last dental care _____ Date of last x-rays _____

Check (✓) yes or no if you have had problems with any of the following:

❑Y ❑N	Bad Breath	❑Y ❑N	Grinding or Clenching	❑Y ❑N	Sensitive to Hot	❑Y ❑N	Bleeding Gums
❑Y ❑N	Loose Teeth/Broken Fillings	❑Y ❑N	Sensitive on Sweets	❑Y ❑N	Clicking/Popping of Jaw	❑Y ❑N	Periodontal Treatment
❑Y ❑N	Sensitive on Biting	❑Y ❑N	Food collection in teeth	❑Y ❑N	Sensitive to Cold	❑Y ❑N	Sores/ growths in mouth

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Other information about your dental health or previous treatment _____

Medical History

Physician Name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? ❑ Y ❑ N

If yes, describe _____

Are you currently under physician care? ❑ Y ❑ N If yes, describe _____

Have you ever had a blood transfusion? ❑ Y ❑ N If yes, give approximate dates _____

Have you ever taken Fosamax, Boniva, Actonel, Zometa or any other medications containing bisphosphonates? ❑ Y ❑ N

Do you use tobacco? ❑ Y ❑ N Do you use controlled substances? ❑ Y ❑ N

Women: Are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking any form of birth control? ❑ Y ❑ N

Are you allergic to any of the following?

Aspirin	❑ Y ❑ N	Latex	❑ Y ❑ N	Acrylic	❑ Y ❑ N	Sulfa Drugs	❑ Y ❑ N
Penicillin	❑ Y ❑ N	Codeine	❑ Y ❑ N	Metal	❑ Y ❑ N	Local Anesthetics	❑ Y ❑ N

Check (✓) yes or no if you have ever had any of the following:

❑Y ❑N	Anaphylaxis	❑Y ❑N	Cortisone Treatments	❑Y ❑N	Hepatitis A	❑Y ❑N	Radiation Treatment
❑Y ❑N	Tuberculosis	❑Y ❑N	Anemia	❑Y ❑N	Hepatitis B or C		
❑Y ❑N	Ulcer / Colitis	❑Y ❑N	High Blood Pressure	❑Y ❑N	Rheumatic / Scarlet Fever	❑Y ❑N	Respiratory Disease
❑Y ❑N	Artificial Heart Valves	❑Y ❑N	Diabetes	❑Y ❑N	HIV / AIDS	❑Y ❑N	Venereal Disease
❑Y ❑N	Artificial joints	❑Y ❑N	Epilepsy / Seizures			❑Y ❑N	Shingles
❑Y ❑N	Asthma	❑Y ❑N	Fainting	❑Y ❑N	Jaw Pain	❑Y ❑N	Shortness of Breath
❑Y ❑N	Atopic (allergy prone)	❑Y ❑N	Food Allergies	❑Y ❑N	Kidney Disease or Malfunction	❑Y ❑N	Skin Rash
❑Y ❑N	Back problems	❑Y ❑N	Glaucoma		Liver Disease		
❑Y ❑N	Headaches	❑Y ❑N	Mitral Valve Disease	❑Y ❑N			Spina Bifida
❑Y ❑N	Heart Murmur	❑Y ❑N	Nervous Problems	❑Y ❑N	Stroke	❑Y ❑N	
❑Y ❑N	Heart Trouble/ Disease	❑Y ❑N	Pacemaker/Heart Surgery	❑Y ❑N	Surgical Implant	❑Y ❑N	Blood Disease
❑Y ❑N	Psychiatric Care	❑Y ❑N	Circulatory Problems	❑Y ❑N	Swelling of Feet or Ankles	❑Y ❑N	Cancer
❑Y ❑N	Tonsillitis	❑Y ❑N	Arthritis/ Rheumatism/Gout	❑Y ❑N	Thyroid Disease / Malfunction	❑Y ❑N	Chemical Dependency
❑Y ❑N	Cough Up Blood			❑Y ❑N	Herpes	❑Y ❑N	Hemophilia / Abnormal Bleeding
				❑Y ❑N	Cough, Persistent	❑Y ❑N	Rapid Weight Loss or Gain
						❑Y ❑N	Chemotherapy

Have you ever had any serious illness not listed above? _____

Is patient currently taking any medications? If yes, list all: _____

Does the patient have drug allergies? If yes, list all: _____

Contract for Services

PLEASE INITIAL EACH PARAGRAPH AND SIGN BELOW TO ACKNOWLEDGE YOUR AGREEMENT

_____ **I agree to pay for my service in full as estimated at the time of treatment,** unless prior arrangements have been made. **I understand that I am financially responsible for all charges whether or not paid by insurance**; and **I agree I will pay any remaining balance that my insurance company does not pay in a timely fashion.**

_____ I authorize my insurance to pay to Dr. Minnigh all benefits otherwise payable to me for services rendered. I authorize his office to release all information necessary to secure payment. This agreement acts as my signature on insurance forms.

_____ I have reviewed all this information; it is accurate to the best of my knowledge. I understand this information will be used to help determine appropriate and healthful dental treatment. I will inform Dr. Minnigh if there is a change in medical status.

Signature _____ Date _____

Relation to Patient _____