Welcome to . . .

Dental Associates of the Ozarks

Gary M. Ledford, D.D.S., P.C.

Smile, You've Found The Right Dentist For Your Entire Family To Help You Show Your Best Asset . . . Your SMILE!

Thank you for selecting us! Our goal is to provide you with the best possible dental care. To help us meet your dental needs, please take a few minutes to fill out this form to help us get to know you. If you have any questions or need assistance, please ask us. We will be happy to help you.

Personal Information **Today's Date** _____

Name _____ Birthdate _____

Name I prefer to be called by _____

Home Phone Number ( ) _____ Cell ( ) _____

Address _____

City _____ State _____ Zip Code _____

How long at this address _____ If less than 1 year, please list your former address

Former Address _____

Social Security # _____ Driver's Lic. (State & #) _____

Marital Status - Single Married Widowed Separated Divorced

Name of Spouse _____ Name of Children _____

Your Employer's Name & Address _____

_____

Work Phone Number ( ) _____ May we call you at work if necessary? Y N

Type of work performed or position title _____

How long have you worked with this company? _____

How did you learn of our office _____

Is there someone we may thank for referring you to us? _____

Emergency Contact _____ Phone Number _____

Items A through G are optional just to help us get to know you.

A. What school did you last attend? _____

B. What are your outside interests or hobbies? _____

C. What professional or trade organizations do you belong to? _____

D. What clubs, fraternal, or social organizations do you belong to? _____

E. What is your favorite place for lunch? _____ Dinner? _____

F. What is your favorite book? _____ TV show? _____

G. Do you have a favorite sport or sports team? _____

Health Information

Name of your Physician _____ Physician's Phone #( ) _____

His/Her Address _____

Have you had? (please circle Y or N. Do Not Leave Blank)

Allergies::	Drug	Y	N	If yes, list drug(s) _____
	Non-drug	Y	N	If yes, describe _____
Artificial Joints/Valves		Y	N	If yes, describe _____
Asthma/Hay Fever (circle)		Y	N	If yes, describe _____

PLEASE CONTINUE

Chemotherapy	Y	N	If yes, for what _____
Diabetes	Y	N	If yes, date of initial onset _____
Excessive Bleeding	Y	N	If yes, describe _____
Glaucoma	Y	N	If yes, is it controlled with medication Y N
Heart Ailment (Any)	Y	N	If yes, be specific _____
Heart Murmur	Y	N	If yes,date of initial onset _____
Hepatitis	Y	N	If yes, which type _____
High Blood Pressure	Y	N	If yes, is it controlled with medication Y N
HIV Positive/Aids	Y	N	If yes, date of the positive result _____
Radiation Treatments	Y	N	If yes, for what _____
Rheumatic Fever	Y	N	If yes, when _____
Stroke	Y	N	If yes, when _____
Tuberculosis	Y	N	If yes, when _____
Are You Pregnant	Y	N	If yes, due date _____
Are You in Good Health	Y	N	If not, describe _____

Long term medications being taken for a chronic health problem. (please list them)

_____ _____

_____ _____

_____ _____

Short term medications being taken for an acute health problem. (please list them)

_____ _____

_____ _____

Do you smoke? Y N Do you chew tobacco or snuff? Y N

Do you drink coffee, tea or sodas? Coffee Tea Soda If yes, how many per day _____

Is there any other information regarding your medical history of which you feel we need to be made aware?

_____

Dental Information

Why have you come to the dentist today? _____

When was your last dental visit? _____ Reason for that visit? _____

How do you feel about your past dental treatment? _____

How would you describe the general condition of your teeth? _____

Do you want to present a particular image to others? _____ If yes, what kind of image? _____

How important is it to you to eliminate future dental problems? _____

If you could change the appearance of your teeth, what would you change? _____

If you have has a local anesthetic (the shot which makes you numb), did you have any problems or reactions to the anesthetic? Y N If yes, please describe _____

The following are Yes - No questions regarding your **periodontal health.**

Do your gums bleed when you brush your teeth, floss or use a toothpick?	Y	N
Are your gums red, swollen or tender?	Y	N
Are your gums pulling away from your teeth?	Y	N
Are your permanent teeth loose or separating?	Y	N
Do you have bad breath?	Y	N
Do you have a bad taste in your mouth that doesn't go away?	Y	N

PLEASE CONTINUE

The following are Yes - No questions regarding jaw-joint problems known as **Temporomandibular Joint (TMJ) Dysfunction.**

Do you have headaches, particularly present upon awakening?	Y	N
Do you have pain in or around the ear which often spreads to the face?	Y	N
Do you have clicking, popping, or grating sounds when opening or closing your mouth?	Y	N
Do you have pain or difficulty in chewing, yawning, or opening you mouth wide?	Y	N
Do you clench your teeth?	Y	N
Has anyone mentioned you grind your teeth while sleeping?	Y	N

Is your dental anxiety level LOW MEDIUM HIGH?
Can you tell us why?_____

Nitrous Oxide (Laughing gas) is available to help you relax, however, there is an additional fee and insurance companies do not normally cover this fee.

Would you like to use **Nitrous Oxide** during treatment?	Y	N
During Treatment, would you like to use a set of **Headphones?**	Y	N

Account Information
Person(s) Responsible for this account (if different)_____
His/Her Date of Birth_____ His/Her Soc. Sec. #_____
Address and phone number (if different than patient's.)_____
_____

If you have dental insurance, the name of the insurance company_____
Insured's Name_____ Insured's Soc. Sec. #_____
Insured's Date of Birth_____ Relationship to Patient_____
Insured's Employer_____
Group Number_____ Policy Number_____ Deductible_____
Method of payment or co-payment will be **Cash Check Credit card**
I wish to discuss other financial arrangements Yes No

Please read the following and sign on the bottom of the next page.

Payment or Insurance Co-payments are due at the time services are rendered. We ask you to please remember this is a dental office, not a financial institution. Any deviation of this policy MUST be established IN ADVANCE with the Office Manager.

A FINANCE CHARGE is assessed on all accounts not paid in full within 30 days of the statement billing date. This charge is computed by a periodic rate of 1 ½% (or a minimum of 50 cents on balances under $34.00) per month which is an ANNUAL PERCENTAGE RATE of 18% applied to the previous balance. To avoid additional FINANCE CHARGES, the balance must be paid in full before the next billing date. **If it becomes necessary to effect collection of this account, the undersigned agrees to pay all costs and expenses, including attorney fees.**

PLEASE CONTINUE

Concerning Insurance

1. Patients who carry dental insurance should remember that professional services are rendered and charged to the patient and not to the insurance company.

2. As a courtesy to our patients, this office will file claims directly to the insurance company. Many clerical hours are devoted to filling out these forms to derive your best possible coverage. Most often, our office will not receive payment for many weeks. If you have a deductible or are aware of what percentage your insurance company will not pay for, this amount is due at the time services are rendered.

3. Please remember, every insurance policy is different. We do not render services on the basis that insurance companies will pay our fees. Your particular policy will probably only pay a portion of our charges. This portion or percentage varies with the type of treatment. Please keep in mind that charges incurred which are not paid for by your insurance are your responsibility.

4. This office cannot accept responsibility for negotiating a settlement on a disputed claim. You are responsible for payments of your account within the limits of our credit policy.

5. Please help us keep your insurance claims up to date by bringing us your insurance card and notifying us of any changes. Also, a booklet describing your exact coverage would be of great benefit. Often times, insurance companies will not release this information to us, only to the insured.

Concerning Appointments

We strive to schedule all patients with adequate time for the treatment needed and try our best to always run on time. You will be notified if we run more than 15 minutes behind. Likewise, if you are running late we would appreciate knowing. The worst thing for us is if you do not keep your appointment at all. This prevents us from seeing others in need. Any person who fails to keep an appointment or who fails to call and cancel/reschedule 6 of our business hours (Mon 10-6, Tues 9-6, Wed and Thur 8-5) in advance ***may*** be subject to a $30 fee per ½ hour scheduled.

We reserve the right to require a prepayment equal to the $30 per ½ hour scheduled for anyone in order to reschedule a missed appointment. Should the rescheduled appointment be kept, that prepayment will be applied toward the treatment fees incurred. Should the rescheduled appointment be missed, the prepayment will be applied toward a failed appointment fee that ***will*** be charged. We regret the need to implement this policy, but due to the number of people not giving us adequate office time to contact others in need to fill their appointment time we have been forced to do so.

The Undersigned, hereby authorizes the release of any information relating to all dental claims for benefits submitted on behalf of myself and / or dependents. I also request payment of the insurance benefits to be made to the dentist described on the insurance form. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits of services rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed each particular claim.

I certify the information I have supplied is true to the best of my knowledge. I will notify this office of any changes in my health. I have read, understand, and agree to the above policies.

_____ _____

Patient Signature (parent/guardian must sign if under 18) Date

THANK YOU