~ Welcome ~

Thank you for choosing Dr. Mogren's Practice for your dental treatment. We hope that you find your visit with us to be comfortable and professional. We will strive to provide you our best, personalized care at a reasonable cost. Below are a few of our office policies.

Financial Arrangements and Insurance Overview

After each examination, Dr. Mogren will diagnose any dental needs and also discuss options for treatment. We will then provide you with a detailed estimate outlining the total cost of the chosen treatment and the anticipated amount of insurance will pay toward each procedure.

We have payment options available to help with the out of pocket expenses.

- Cash, Check, or Credit Cards such as Mastercard, Visa , and Discover
- Payment Plans through our finance company "Care Credit". This is a monthly payment plan, which allows 0% interest for up to 18 months, based on credit approval.

For our patients that have dental insurance, we will provide a brief verbal summary of how your dental insurance works. Essentially, dental insurance coverage varies depending on the classification of the dental procedures performed. Different insurance policies have different rates of coverage.

The portion of the fee that is not covered by insurance is your responsibility and will be collected at the time the dental service is provided. Sometimes the insurance company doesn't pay what their portion was estimated to be. In these cases, you will be billed and responsible for the remainder of the payment.

Appointments and Cancellations

When we make your appointment, we are reserving a room for your particular needs. We ask that if you need to change an appointment, please give us **at least 24 hours notice.** This courtesy makes it possible to give your reserved room to another patient who would like it. We feel that our patient's time is valuable as well as our time.

There is a charge for not showing up for scheduled appointments. *Repeated cancellations or missed appointments will result in loss of future appointment privileges.*

Once again, welcome to our practice! It is our goal to help you feel and look your best through excellent dental care. From regular cleanings to smile makeovers, we have the desire and ability to help you achieve a healthier, happy smile!

NATHAN W. MOGREN D.M.D.
Doctor of Medical Dentistry

PATIENT INFORMATION (CONFIDENTIAL)

Name ______________________________ Date ____________
First MI Last

Address ______________________________

City ____________ State ______ Zip Code ________

Phone (Home) ________ (Cell) ________ (Work) ________

Email ______________________________

SS# ____________ Birth Date ____________

❑ Male ❑ Female ❑ Married ❑ Divorced ❑ Single ❑ Minor ❑ Other

Whom may we thank for referring you? ______________________________

RESPONSIBLE PARTY (if a minor)

Guarantor ____________ Relationship to Patient ____________

Address ____________ Phone ____________

Birth Date ____________ SS# ____________

Employer ____________ Work Phone ____________

Is this person currently a patient in our office? ❑ Yes ❑ No

PRIMARY DENTAL INSURANCE INFORMATION

Insured ____________ Relationship to Patient ____________

Birth Date ____________ SS# ____________

Employer ____________ Work Phone ____________

Employer Address ____________

City ____________ State ______ Zip Code ________

Insurance Co. ____________ Phone ____________

Group# ____________ ID# ____________

Insurance Address ______________________________

City ____________ State ______ Zip Code ________

SECONDARY DENTAL INSURANCE INFORMATION

Insured ____________ Relationship to Patient ____________

Birth Date ____________ SS# ____________

Employer ____________ Work Phone ____________

Employer Address ____________

City ____________ State ______ Zip Code ________

Insurance Co. ____________ Phone ____________

Group# ____________ ID# ____________

Insurance Address ______________________________

City ____________ State ______ Zip Code ________

X ______________________________

Signature of Patient or Parent/Guardian if Minor

PATIENT MEDICAL HISTORY

Dental health is important to one's overall health. To responsibly address your dental concerns, we need basic information regarding your health. Please answer the following questions:

Please list the medications you are taking:

____

____

____

____

Are you allergic to:	**YES**	**NO**
Any antibiotics/medications	❑	❑
Please list: ________________		
Latex	❑	❑
Jewelry Metals (nickel) etc.	❑	❑

Have you ever had:	**YES**	**NO**	**APPROXIMATE DATE:**
A Heart Transplant	❑	❑	___/___/___
A Heart Valve Replacement/Repair Surgery	❑	❑	___/___/___
A Heart Attack	❑	❑	___/___/___
Artificial Joint Surgery	❑	❑	___/___/___
An Organ Transplant	❑	❑	___/___/___
Cancer Treatment-Radiation/Chemotherapy/Surgery	❑	❑	___/___/___
A Stroke	❑	❑	___/___/___
High Blood pressure	❑	❑	___/___/___
Hepatitis or Liver Disease	❑	❑	___/___/___
Tuberculosis	❑	❑	___/___/___
Diabetes	❑	❑	___/___/___
A Pacemaker	❑	❑	___/___/___
AIDS/HIV	❑	❑	___/___/___

For Women Only:	**YES**	**NO**
Are you pregnant?	❑	❑
Congratulations! Due Date: __________		
Are you nursing:	❑	❑

Are you addicted to:	**YES**	**NO**
Tobacco Smoke	❑	❑
Chewing Tobacco	❑	❑
Narcotics	❑	❑
Alcohol	❑	❑

Dental Questions, Please Explain:

When, approximately, was your last dental visit? ________________

Do your gums bleed? ________________

Do you have sensitive teeth? ________________

Do you get headaches? ________________

If you could change anything about your smile, what would you change? ________________

____

What is the most important thing that you expect of your dentist? ________________

____

My signature below confirms that this health questionnaire is accurate to the best of my knowledge.

Signature: ________________________ Date: ____________