Patient Demographics and Health History

Basic Patient Info:

First Name: _____ Last Name: _____ MI: _____

DOB: _____ Sex: _____ Marital Status: ○ Single ○ Married ○ Child ○ Other

E-mail address: _____

Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip: _____

Emergency Contact Info:

Name: _____ Phone #: _____

Relationship to patient: _____

Allergies:

○ Acetaminophen/Tylenol	○ Acrylic	○ Amoxicillin
○ Aspirin	○ Barbiturates	○ Clindamycin
○ Codeine	○ Erythromycin	○ General Anesthetics
○ Ibuprofen/Motrin/Advil	○ Iodine	○ Latex
○ Local Anesthetics	○ Metal	○ Penicillin
○ Sedatives	○ Sulfa	○ No Allergies

Others (not listed): _____

_____

Medical Conditions:

○ AIDS/HIV	○ Alzheimer's	○ Anaphylaxis
○ Anemia	○ Angina	○ Anxiety
○ Any Immune Deficiency	○ Any Type of Implant	○ Any Type of Transplant
○ Arthritis	○ Artificial Heart Valves	○ Artificial Joints
○ Asthma	○ Back Problems	○ Bad Breath
○ Bleeding Gums	○ Blood Disease	○ Blood Transfusion
○ Breathing Problems	○ Bruise Easily	○ Bulimia
○ Cancer	○ Cardiovascular Disease	○ Chest Pain
○ Circulatory Problems	○ Clicking in Jaw	○ Congenital Heart Disorder
○ Convulsions	○ Currently Nursing	○ Currently Pregnant
○ Depression	○ Diabetes	○ Difficulty Chewing
○ Difficulty in Opening Jaw	○ Drug Addiction	○ Ear Aches
○ Easily Winded	○ Emphysema	○ Epilepsy or Seizures
○ Excessive Bleeding	○ Excessive Thirst	○ Fainting or Dizzy Spells
○ Finger Nail Biting	○ Frequent Cough	○ Frequently Tired

○ Reflux/Heartburn	○ Gastrointestinal Disease	○ Glaucoma
○ Head/Neck Injury	○ Headaches	○ Heart Attack/Failure
○ Heart Disease	○ Heart Murmur	○ Heart Rhythm Disorder
○ Heart Surgery	○ Heart Trouble	○ Hemophilia
○ Hepatitis A	○ Hepatitis B	○ Hepatitis C
○ Herpes	○ High Blood Pressure	○ Hives or Rash
○ HPV	○ Hypoglycemia	○ Irregular Heartbeat
○ Jaundice	○ Kidney Disease	○ Leukemia
○ Lip or Cheek Biting	○ Liver Disease	○ Loose teeth/broken fillings
○ Low Blood Pressure	○ Lung Disease	○ Mitral Valve Prolapse
○ Mouth Sores/Growths	○ Neurological Disorders	○ Osteopenia
○ Osteoporosis	○ Pacemaker	○ Pain Around Ear
○ Pain in Your Jaw (TMJ)	○ Parathyroid Disease	○ Periodontal Disease
○ Recent Weight Loss	○ Recurrent Infections	○ Renal Dialysis
○ Respiratory Problems	○ Rheumatic Fever	○ Rheumatism
○ Scarlet Fever	○ Shingles	○ Sickle Cell Disease
○ Sinus Problems	○ Sleep Apnea	○ Slow Healing Wounds
○ Special Diet	○ Stomach Problems	○ Stroke
○ Swelling of Limbs	○ Teeth Grinding/Clenching	○ Thyroid Disease
○ Tonsillitis	○ Tooth Pain	○ Tooth Sensitivity (Hot/Cold)
○ Tooth Sensitivity (Sweets)	○ Tooth Sensitivity (Biting)	○ Tuberculosis (TB)
○ Tumors or Growths	○ Ulcers	○ Use of Controlled Substances

Others (not listed): _____

_____

Medical Treatment:

○ Chemotherapy	○ Psychiatric Treatment	○ Radiation Treatment

Others (not listed): _____

Medication:

○ Any Bisphosphonates	○ Actonel	○ Boniva
○ Cortisone Medicine	○ Fosamax	○ Oral Contraceptives
○ Test Medication	○ Reclast	○ Others (list below)

Others (not listed): _____

_____

_____

_____

Medical History:

Physician's Name: _____

Have you had any surgeries, serious illness, or hospitalizations within last 5 years? (If yes, please explain): _____

_____

Insurance Info: (if none, skip to next section)

Insurance Company: _____

Subscriber Name: _____ DOB: _____

Relationship to Subscriber: _____ Employer: _____

Group #: _____ Policy/ID #: _____

Secondary insurance (if none, skip to next section)

Insurance Company: _____

Subscriber Name: _____ DOB: _____

Relationship to Subscriber: _____ Employer: _____

Group #: _____ Policy/ID #: _____

Referral Info:

Another patient (name): _____

Another Doctor (name): _____

Other (please list): _____

Agreements:

The following is a statement of our Financial Policy, which we require that you read, agree to, and sign the acknowledgment prior to any treatment. Your clear understanding of the Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility upon arrival at your first appointment.

INSURANCE/PAYMENTS
Payment for all dental services performed must be paid at the time service.

Our dentists are in-network providers with Delta Dental Premier. Our office can submit to any dental insurance carrier. However, out-of-network insurance benefits will be based on the insurance carriers usual and customary coverage allowance.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. Family Dental Center will help prepare the patient's insurance forms or assist in making collections from insurance companies. This dental office cannot render services on the assumption that our charges will be paid by an insurance company. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. If your claim is denied or payment is not received, you will be responsible for paying the full amount at that time. If you are paid by the insurance company instead of our practice, you then become responsible for the total account balance and payment would be expected immediately.

As a condition of treatment by Family Dental Center, we require that you pay the deductible/co-payment, which is the estimated amount, not covered by your insurance company, by cash, check or credit card at the time we provide the service to you. Family Dental Center depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

I hereby authorize payment of insurance benefits directly to the dentist or dental group. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand that I am financially responsible for payment in full of all charges not paid by insurance.

We ask that you sign the acknowledgment, and/or any other necessary documents that may be required by your insurance company, and that will serve as your electronic signature on the Administration Forms for submission to insurance.

DELINQUENT PAYMENTS
It is our policy to charge a finance fee for outstanding patient balances. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. In addition, all payments returned due to non-sufficient funds will be subject to a fee.

MINORS NOT ACCOMPANIED BY AN ADULT
The minor patient or their parent/guardian, are responsible for payment at time of service. If the minor is not accompanied to the appointment by parent/guardian, we ask that you make payment prior to their scheduled appointment time.

We may ask that the minor patient update their medical history at their appointment.

MISSED APPOINTMENTS
If you are unable to make an appointment, a 24-hour notice is appreciated. If there is a history of missed or cancelled appointments, we reserve the right to see the patient on a same day basis only or dismiss the patient from our office.

Please sign below acknowledging that you have read the Financial Policy and have had the opportunity to read the Privacy Policy.

Signature: _____ Date: _____