Our Family Dentist

Patient Information

Full Name: _____ Preferred Name: _____

Birth Date: _____ Social Security No: _____ Sex: M F

Address: _____ City/Sate/Zip: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Email Address: _____ Employer: _____

Spouse's Name (Parent's Name if Minor) & Birth Date: _____

How did you hear about our office? _____

Dental Insurance Information

Dental Insurance Company: _____

Insurance Company State: _____ Phone Number: _____

Policy Holder's: Name: _____ Birth Date: _____ SSN: _____

Group or Policy Number: _____ Identification Number: _____

Insurance Release

I hereby authorize the release of any information to my insurance company, including diagnosis and/or treatment and records of examinations. I understand that my dental insurance is a contract between me and the insurance carrier and not between Our Family Dentist and the insurance carrier. I fully understand that it is my responsibility for all dental treatment regardless of insurance coverage. I understand that my insurance carrier is a financial institution, not a determining party of needed treatment.

Our Financial Policy

I understand that I will be expected to pay for services in full on the date services are rendered. Our Family Dentist will file insurance claims as a courtesy to our patients. Any unpaid balances from the insurance company are the patient's responsibility. If your insurance company has not paid on your claim within 45 days, the full balance will automatically be transferred to you. In the event that your insurance company denies payment of a service, you are responsible for that fee. After 90 days of non-payment, your account will be turned over to a collection attorney or agency. I agree to pay all finance charges, collection costs, attorney fees, and any other costs that may be incurred. If your account is turned over to collections you will be dismissed as a patient of this practice.

X-RAYS- Please note if you are eligible for the $49 exam and x-rays as a new patient there will be a $50 fee to transfer those x-rays to any other doctor's office.

Cancellation Policy- If you cancel your appointment with less than 24 hour notice there will be a $25 fee applied to your account. If your appointment is scheduled for a Monday you must call Friday before noon to cancel.

Please list the persons whom we may discuss your dental treatment, diagnosis, and/or financial responsibility with:

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Patient Signature_____ Date: _____

(or legal guardian)

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Our Family Dentist

Medical History

Physician: _____ Phone Number: _____

Do you have (or ever had) any of the following conditions or problems: **(Circle Yes or No for each)**

Acetaminophen Allergy	Yes/No	Cortisone Treatments	Yes/No	Hepatitis A B C	Yes/No	Respiratory Problems	Yes/No
AIDS/HIV	Yes/No	Cough (Persistent)	Yes/No	Herpes	Yes/No	Rheumatic Fever	Yes/No
Allergies (Seasonal)	Yes/No	Diabetes	Yes/No	High Blood Pressure	Yes/No	Scarlet Fever	Yes/No
Anemia	Yes/No	Emphysema	Yes/No	Iodine Allergy	Yes/No	Sinus Problems	Yes/No
Anxiety	Yes/No	Epilepsy	Yes/No	Jaundice	Yes/No	Stomach Problems	Yes/No
Arthritis/Rheumatism	Yes/No	Excessive Bleeding	Yes/No	Kidney Disease	Yes/No	Stroke	Yes/No
Artificial Heart Valve	Yes/No	Fainting/Dizziness	Yes/No	Latex Allergy	Yes/No	Sulfa Allergy	Yes/No
Artificial Joints	Yes/No	Glaucoma	Yes/No	Liver Disease	Yes/No	Thyroid Disease	Yes/No
Aspirin Allergy	Yes/No	Growths	Yes/No	Mitral Valve Prolapse	Yes/No	Tobacco Use	Yes/No
Asthma	Yes/No	Head Injuries	Yes/No	Pacemaker	Yes/No	Tuberculosis	Yes/No
Back Problems	Yes/No	Headaches	Yes/No	Penicillin Allergy	Yes/No	Tumors	Yes/No
Cancer	Yes/No	Heart By-Pass	Yes/No	Periodontal Disease	Yes/No	Ulcers	Yes/No
Chemical Dependency	Yes/No	Heart Disease	Yes/No	Pre Med	Yes/No	Venereal Disease	Yes/No
Circulatory Problem	Yes/No	Heart Lesions	Yes/No	Pregnancy (Currently)	Yes/No	Other (List Below)	Yes/No
Codeine Allergy	Yes/No	Heart Murmur	Yes/No	Psychiatric Care	Yes/No		
COPD	Yes/No	Heart Problems	Yes/No	Radiation/Chemo	Yes/No		

***Are you taking a blood thinner? Yes/No**

Other Conditions: _____

_____

Please list any medications you are currently taking: _____

_____

Do you have an immediate dental problem (explain): _____

_____

I acknowledge that the above information is true and correct to the best of my knowledge and if there are any changes in my medical history it should be reported to Our Family Dentist as soon as possible.

Patient Signature_____ Date: _____
(or legal guardian)

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