MEDICAL HISTORY FORM

PATIENT INFORMATION (PLEASE PRINT IN BLOCK LETTERS)

Last Name:	First Name:	Middle Initial:
Home Address:		Apt #:
City:	State:	ZIP Code:
Home Phone: ( ) -	Cell Phone: ( ) -	Work Phone: ( ) -
Sex: Female / Male	Date of birth: / / Age:	Marital: Single/Married/Divorced/Widowed
E-mail:		Occupation:
Emergency Contact:	Relationship:	Phone: ( ) -

ACCOUNT INFORMATION -FOR THE RESPONSIBLE PARTY OR GUARDIAN OF A PATIENT THAT IS UNDER AGE 18.

Name: (Last)	(First)	(Middle Initial)
Home Address: (if different with patient)		Apt #:
City & State:	ZIP Code:	Sex: Female / Male
Home Phone: ( ) -	Cell Phone: ( ) -	Work Phone: ( ) -
SSN: (for insurance) - -	Date of birth: / /	Marital: Single/Married/Divorced/Widowed
Relation to Patient: ❑Self ❑Spouse ❑Parent ❑Guardian ❑Facility		Occupation:

DENTAL INSURANCE - (NO DMO & HMO PLANS)

Dental Plan Name (Primary):	Group #::	Subscriber ID#:
Name of Subscriber:		Date of birth: / /
Dental Plan Name (Secondary):	Group #::	Subscriber ID#:
Name of Subscriber:		Date of birth: / /

DENTAL AND MEDICAL HISTORY

Primary Care Physician:	Phone:
Current Medications:	
Female Patient: ❑Pregnant _____weeks ❑Trying to get Pregnant ❑Nursing ❑Taking Oral contraception's	
ALLERGENS: ❑Aspirin ❑Acrylic ❑Amoxicillin ❑Codeine ❑Dental Anesthetics ❑Erythromycin ❑Ibuprophine ❑Jewelry ❑Latex ❑ Metals ❑Percocet ❑Penicillin ❑Tetracycline ❑Vicodin	

PLEASE CHECK √ ALL THAT APPLY

Y/N	Y/N	Y/N	Y/N
❑❑Abnormal Bleeding	❑❑Emphysema	❑❑Psychiatric Problems	❑❑Orthodontic Treatment
❑❑Alcohol Abuse	❑❑Epilepsy	❑❑Radiation Therapy	❑❑Sensitivity to cold/hot
❑❑Allergies	❑❑Fainting Spells	❑❑Rheumatic Fever	❑❑Sores/growths in mouth
❑❑Anemia	❑❑Fever Blisters	❑❑Shingles	
❑❑Angina Pectoris	❑❑Frequent Headaches	❑❑Sickle Cell Disease	**❑None of the above**
❑❑Arthritis	❑❑Glaucoma	❑❑Sinus Problems	
❑❑Artificial Bones	❑❑HIV + AIDS	❑❑Stroke	***Additional Information:**
❑❑Artificial Heart Valve	❑❑Hay Fever	❑❑Thyroid Problems	
❑❑Asthma	❑❑Heart Attack	❑❑Tuberculosis	
❑❑Blind / Sight Impaired	❑❑Heart Surgery	❑❑Ulcers	
❑❑Blood Transfusion	❑❑Hemophilia	_____	
❑❑Cancer _____	❑❑Hepatitis A/B	❑❑Bad Breath	
❑❑Colitis	❑❑Hepatitis C	❑❑Bleeding Gums	
❑❑Congenital Heart Defect	❑❑Herpes	❑❑Blisters on lips	
❑❑Cosmetic Surgery	❑❑High Blood Pressure	❑❑Clicking Jaw	
❑❑Deaf / Hearing Impaired	❑❑Kidney Problems	❑❑Dry Mouth	
❑❑Diabetes	❑❑Liver Disease	❑❑Fingernail Biting	
❑❑Difficulty Breathing	❑❑Low Blood Pressure	❑❑Grinding Teeth	
❑❑Drug Abuse	❑❑Pace Maker	❑❑Jaw Pain	

By signing below, I agree that I am the legally responsible party of the patient, I have read and understand the privacy practices related to this office (HIPPA Act), information on this form is current and correct to the best of my knowledge, and I will update this information with this office before treatment is performed. Upon request, a new Medical History Form will be filled out every 3 years.

X_____ _____
Signature of Responsible Party Date

FOR OFFICE USE: REVIEWED BY DOCTOR: _____ DATE:_____

UPDATES: DATE_____ ADDITIONAL UPDATES: _____ PATIENT'S INITIAL:_____ REVIEWED BY:_____

DATE_____ ADDITIONAL UPDATES: _____ PATIENT'S INITIAL:_____ REVIEWED BY:_____

- **Patient Payments:** Patient's payment portion is expected upon completion of each time of service. A deposit will be required at each visit for any multi-visit service. We accept MasterCard, Visa, Discover, Money Order, CareCredit, cash, and check to better serve you.

- **Patient Copayments and Deductibles:** Most dental plans will only pay a percentage of the contracted fee for a covered service and you are responsible for your percentage portion which is called a patient copayment. This means that the insurance and the customer both pay some of the charges for dental work covered by their plan. A deductible is the amount of expenses that is paid by the insured or patient before the insurance will pay for any covered expenses. In about 30 days you and the dentist in most cases will receive the "explanation of benefits" (EOB) from the insurance usually indicating the services that are covered, any insurance payment to the provider, how much was paid by your dental plan, maximum used in some cases, and how much is your responsibility. Any estimated patient co-payment and any eligible deductible is your financial responsibility.

- **Insurance:** Dental plans are designed to share the cost of dental care. Although we may attempt to provide an accurate estimate of your insurance benefits, we are NOT responsible for their accuracy.

- **Broken Appointment:** It is your responsibility to remember and arrive at your appointment on time. A $25.00 charge per half hour will be billed directly to you for any broken appointment unless a 24 hour notice is provided. *We have an automated system to remind your appointment by e-mail, text or voice message.* If you break multiple appointments, our office reserves the right to discharge you and/or all patients under the account from this practice.

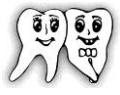
- **Prescriptions:** In most cases, you will need to be seen in regards to a request or refill for a prescription and/or a less or non-addictive prescription will be provided. *Our office reserves the right not to see any patient seeking only medication and not treatment and the right to deny a patient request or refill for a prescription.* In most cases, we will not provide or refill a prescription if you are referred out or seen another practice, specialist, or physician. A letter from your physician may be required to confirm any allergic reaction or pre-medication. *This office policy will help prevent addiction or overmedication to the patient and to help provide the appropriate diagnosis and treatment.* Your cooperation is greatly appreciated regarding our prescription policy.

- **Incomplete Services:** It is your responsibility to provide any expected payments and to schedule and arrive for your appointments. Our office deserves to be paid for any service that is completed but not delivered or for any office expenses and work performed for any incomplete service. Any multi-visit service not finished within a 60 day period or within the time limit recommended, the case may be closed and a claim may be submitted for the incomplete service to the insurance for the covered service but the patient is responsible for any remaining balance or determined by the work performed and any related expenses. An additional charge may apply if we retreat or redo any service related to the incomplete multi-visit service or incomplete treatment plan.

- **Collections and Unpaid Balances:** A late fee charge of $25.00 will be billed directly to you for any new or old patient balance 30 days past due or older. It is your responsibility to provide or update any valid contact information while your account has a balance. Please be aware that our office reserves the right not to see any patient with an account that has a past due balance or with any account on hold or under collection status. *Any account balance that is 90 days overdue and/or mail is returned in regards to a billing statement may be referred to a collection agency.* You understand that if your account is forwarded to a collection agency, in addition to the principal obligation, you will also be responsible for a collection fee equal to 30% of the principal obligation including a 10% additional charge when an account is elevated to legal status. (Example: if your principal obligation is $100.00, your balance will be $130.00 if your account is forwarded to a collection agency for a 30% collection charge). You are responsible for any and all office, collection agency, attorney, legal fees, and court expenses related to the collection of any balance you have with this office or with the collection agency and you understand that you will be discharged from this practice if your account is under collection status with our office until the account balance is paid in full and it is your responsibility to immediately find an alternative dental provider. You agree to contact the collection agency for the correct balance or payment related concerns.

- **Miscellaneous:** *We will not guarantee or be liable for any work performed in relation to fix or repair any work performed by another office or due to patient negligence.* You may be required to fill out a release form for copies of your records (a fee may occur for this service). A copy of records may only be provided to the responsible party or other individual with signed permission from the responsible party (photo ID may be required) in order to protect private information. Any treatment plan may be subject to change without notice or depending on condition and outcome of treatment. Most work is guaranteed for 1 year. This financial agreement including all office policies, obligations, charges, and procedures may be subject to change without notice.

Any reference to the patient for payment or responsibility aspects in this document are in regards to the responsible party of the patient. Any alteration of this document without management approval does not change the original document and such act is not acceptable and may result in patient discharge. By signing below, you agree that receiving our services indicates your acceptance of responsibility that all charges you incur are your responsibility regardless of your insurance coverage and you also agree that i*t is your responsibility to understand all aspects of your dental policy and be aware of current or any changes to the coverage and benefits of your dental plan regardless of any conflict or dispute between other contracts or agreements*. By signing below, I agree that I am the legally responsible party (competent patient 18 or older / parent / guardian / facility) of the patient and that I have read, understand, and agree to the terms and conditions stated above and I also agree to abide by all its guidelines in order for the patient to receive any services from this dental practice.



X_____ **X** _____ **X**_____

Signature of Responsible Party **Print Full Name of Responsible Party** **Date**