Family Dental Care Center

Welcome

Date_____

PATIENT INFORMATION

Name_____

Street Address_____

City_____ State_____ Zip Code_____

Home Phone_____

Cell _____ Can we text you to confirm appointments? ☐Yes ☐No

Email_____ Can we email you? ☐ Yes ☐ No

Date of Birth_____ Age_____ Sex ☐ M ☐ F

Patient's Information (unless child, then parent's information)

Social Security #_____

Employer_____

Employer's Address_____

Work Phone_____

Spouse's Name_____

Spouse's Birthdate_____

Spouse's Employer_____

Spouse's Social Security #_____

Whom may we thank for referring you?_____

EMERGENCY CONTACT (please specify someone who does not live in your household)

Name_____ Relationship_____

Home Phone_____ Work Phone_____

HEALTH HISTORY

Physician's Name_____ Physician's Number_____

Please check any of the following that apply to you:

☐AIDS	☐Epilepsy	☐Psychiatric Care
☐Arthritis	☐Fainting or Dizziness	☐Radiation Treatment
☐Artificial Heart Valves	☐Glaucoma	☐Respiratory Disease
☐Artificial Joints	☐Heart Murmur	☐Rheumatic Fever
☐Asthma	☐Hepatitis-Type_____	☐Scarlet Fever
☐Back Problems	☐Herpes	☐Shortness of Breath
☐Bleeding Abnormally	☐High Blood Pressure	☐Sinus Trouble
☐Blood Disease	☐HIV Positive	☐Stroke
☐Cancer	☐Jaw Pain	☐Swollen Neck Glands
☐Chemical Dependency	☐Kidney Disease	☐Thyroid Problems
☐Chemotherapy	☐Liver Disease	☐Tuberculosis
☐Circulatory Problems	☐Low Blood Pressure	☐Tumor on head or neck
☐Cortisone Treatments	☐Mitral Valve Prolapse	☐Ulcer
☐Diabetes	☐Nervous Problems	Women: ☐Pregnant?
☐Emphysema	☐Pacemaker	☐Nursing?

MEDICATION

Please list any medications you are taking_____

Do you take aspirin?_____ Blood thinner?_____

Any herbal medications? (if yes then list)_____

Caffeine?(if yes list daily intake)_____

ALLERGIES (check all that apply)

☐Aspirin	☐Iodine	☐Penicillin/Amoxicillin
☐Barbiturates	☐Latex	☐Sulfa
☐Codeine	☐Local Anesthetic	☐Other_____

Reviewed Doctor's Initials_____ Patient's Initials_____

DENTAL HISTORY

Reason for today's visit_____

Former Dentist's Name_____

Street Address_____

City_____ State_____ Zip Code_____

Date of last dental visit_____

What services were performed at that time?_____

Date of last dental x-rays_____

Please check any of the following that apply to you:

☐Bad Breath
☐Bleeding Gums
☐Blisters on mouth or lips
☐Tobacco use
☐Clicking or popping jaw
☐Dry Mouth
☐Food collection between teeth
☐Grinding Teeth
☐Gums swollen or tender
☐Jaw pain or tiredness
☐Loose teeth or broken fillings
☐Orthodontic treatment
☐Pain around ear
☐Sensitivity to cold, hot, sweets
☐Sensitivity when biting
☐Sores or growths in mouth

Check the statement that most applies to you:

1. My mouth is:

   ☐Very Comfortable ☐Moderately Comfortable ☐Uncomfortable

2. ☐I think the appearance of my mouth is excellent.
   ☐I am satisfied with the appearance of my mouth.
   ☐I am dissatisfied with the appearance of my mouth.
3. I think my present state of dental health is:

   ☐Excellent ☐Good ☐Poor

What are some questions about dentistry and your oral health that you never had adequately answered?_____

What would you like to change about your smile?_____

Have you had a bad experience in a dental office in the past?_____

What can we do to make your visit today more comfortable?_____

FINANCIAL INFORMATION

Who is responsible for this account?_____ Relationship to patient_____

Address(if different from patient)_____

INSURANCE INFORMATION

Insurance Co Name_____

Ins Co Address_____

Ins Co Phone #_____ Group #_____

Subscriber's Name_____ Subscriber's Birthdate_____

Subscriber's Address(if different from above)_____

Subscriber's Social Security #_____ Relationship to Patient_____

CONSENT

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care. My consent to disclosure or records shall be effective until I revoke it in writing. I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental benefits may pay less than the actual bill for services and that I am financially responsible for payment in full of all accounts. If my account remains unpaid after 90 days, I can be assessed with additional account charges at the rate of 1.5% per month (18% annually). If an office appointment is canceled with less than 24 hours notice, I can be assessed with a cancellation charge of $50. If the bank returns my check I can be assessed with a processing charge of $20. I understand that where appropriate, credit bureau reports may be obtained. I attest to the accuracy of the information on this page.

To Our Valued Patients,

All copayments are due at the time of service. We try to estimate your copayments as accurately as possible. However, because there are thousands of individual policies written by each insurance company, we may have underestimated this copayment at the time of your services. If we have underestimated your copayment you will receive a bill from us indicating your further responsibilities per your insurance contract.

The precise amount owed can be found on your insurance company's Estimate of Benefits (E.O.B.) that was mailed to your home address or via their online services. If you did not receive this or do not understand their explanation, please contact the member services department of your insurance company.

If you are concerned about our estimation, we can send a predetermination in advance of your treatment. This will delay your treatment 2-4 weeks, or until we receive a reply from your insurance company. **Please note: Even with a predetermination your insurance company may reserve the right to change the amount paid as specified on the predetermination. This means that even if a predetermination is received and the work is done in accordance with this, the insurance company may not pay to the stated amount and you will be held for any underpayment.**

Patient of Responsible Party Signature_____ Date_____

Doctor Signature_____ Date_____

Authorization for Release of Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members, you must sign this form. Signing this form will only give information to family members indicated below.

I authorize A-Family Dental Care Center to release my medical and/or billing information to the following individual(s):

1. _____ Relation to Patient: _____

2. _____ Relation to Patient: _____

3. _____ Relation to Patient: _____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information enclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.

You have the right to revoke this consent in writing.

Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Date of Birth: _____

I have been given a copy of A – Family Dental Care Center *Notice of Privacy Practices ("Notice")*, which describes how my health information is used and shared. I understand that the Practice has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Practice Privacy Officer.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

_____ _____
Signature of Patient or Personal Representative Date

_____
Print Name

_____
Personal Representative's Title (e.g., Guardian, Health Care Power of Attorney)

For Facility Use Only: Complete this section if you are unable to obtain a signature.

If the patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

_____

_____

Completed by:

_____ _____
Signature of Practice Representative Date

_____
Print Name

File Original in Patient's Health Care Record