Welcome To Family Dentistry!

About You

Name: _____ Date:_____

Birthdate: _____ Age: _____ Male Female

Home Address:_____

City:_____ Zip:_____ SS#:_____

Home#:_____Cell#:_____W#:_____

E-mail:_____

Employer: _____ Occupation:_____

Spouse's Name:_____ Referred By: _____

_____

Emergency Contact

Name:_____

Phone: _____

Relationship:_____

Preferred Pharmacy

Name: _____

Address:_____

Phone: _____

Insurance Information

Dental Ins Co: _____ Ins Co Phone #: _____

Policy #: _____ Group#:_____

Policy owner's name: _____ Relationship: _____

Policy owner's SS #: _____ Policy owner's birthdate: _____

Policy owner's employer: _____ Occupation: _____

Employer's Address: _____ Phone:_____

*if secondary insurance, please ask for additional form.

How did you hear of us?

- Personal Referral
- Google
- Facebook
- Instagram

Leave us a Google review; receive a free gift at the end of your visit!

Insurance Agreement

To our patients who are requesting that this office carries a balance on their account, to be paid by an insurance company:
This form must be read and signed by the patient or responsible party before we can accept payment directly from an insurance company.

1. I understand and agree that I am responsible for the payment of all treatment fees on my account. If my insurance company fails to pay within 90 days I will be responsible for the full amount.

2. I understand and agree that the amount estimated to remain unpaid by insurance is to be paid by me during treatment.

3. I understand that this office cannot make a totally accurate estimate of all the insurance benefits to be paid for me, since it does not have access to all insurance company records. All fees are only estimated.

4. I understand that after the insurance company pays, there could be a credit remaining to be paid to me.

5. I understand and agree that if upon payment by the insurance company, there is a remaining balance; it is due to be paid in full by me at that time.

6. I understand that after the first 30 days that the balance is not paid there will be finance charges of 3% added at that time. Another 3% finance charge will be added every 30 days there forward that the balance is unpaid.

7. After the office has exhausted the 90 day collection period, if I have not set up and fulfilled a payment plan with the office, I agree to pay a collection fee of 50% times the final balance upon being sent to the collection agency.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (Laminated Sheet on back of clipboard):

Initial: _____

Signature: _____ **Date:** ____/____/_____

Medical History

Medications:

Pain Killers (including aspirin)
Muscle Relaxers
Stimulants
Nerve Pills
Blood Thinners
Tranquilizers
Insulin
Blood Pressure Medication
Bisphosphonates
Others:
SEE ATTACHED LIST

Allergies:

Latex
Penicillin
Amoxicillin
Tetracycline
Aspirin
Dental Anesthetics (Including Epinephrine)
Sulfa
Codeine
Others:

Questions:

Do you use tobacco? Y N
How used?
How Often/Much?
How Long?

Questions For Women:

Are you pregnant? Y N
How Far Along?
OB Letter Faxed/Emailed? Y N
Are you nursing? Y N
Additional Doctor:

Circle all medical conditions that apply:

Frequent Neck Pain
Back Problems
Cosmetic Surgery
X-ray or Cobalt
Chemotherapy
Asthma
Difficulty Breathing
Diabetes/Hypoglycemia
Leukemia
Anemia
GERD
Bleeding Disorder
Glaucoma
Osteoporosis
Thyroid HYPO HYPER

Sinus
Stomach / Ulcers
Psychiatric
Venereal Disease
Alcohol/Drug Abuse
Tuberculosis "TB"
Jaw Problems TMJ/TMD
Cancer/Tumors
Shingles
Hepatitis A B C
HIV+/AIDS/ARC
Arthritis/ Rheumatism
Artificial Bones/Joints
Emphysema
Fainting/Seizures/Epilepsy
Severe/Frequent Headaches

Heart Attack/ Stroke
Heart Condition:
Heart Surg./Pacemaker
Heart Murmur/Arrhythmia
High/Low Blood Pressure
Heart Disease
Congenital Heart Defect
Rheumatic Fever
Mitral Valve Prolapse
Artificial Valves
Chest Pains
Scarlet Fever
Nervousness
Kidney
Liver
Respiratory

Other surgeries or medical conditions: SEE ATTACHED LIST

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

*Update *Office Use Only*	*BP *Office Use Only*	
_____ __/__/____ initials date	__/__ BP	__/__/____ date
_____ __/__/____ initials date	__/__ BP	__/__/____ date
_____ __/__/____ initials date	__/__ BP	__/__/____ date
_____ __/__/____ initials date	__/__ BP	__/__/____ date
_____ __/__/____ initials date		

- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ **Name (print):** _____ **Date:** ____/____/____

Payment & Missed Appointments

Our mission is to deliver the finest, most cost-effective healthcare treatment available today. Following diagnosis, the doctor will advise you of the recommended treatment plan. In addition, we will discuss with you the cost of today's visit and the cost of future treatment.

Payments: for services is due and will be paid at the time that services are rendered. We are sensitive to the fact that some people may not be able to pay cash for their treatment; therefore, we offer several alternative payment programs for your convince. They are:

1. Cash
2. Visa, Master Card, American Express and Discover
3. FSA or HSA
4. Care Credit (Financing) INTEREST FREE (6 and 12 months) alternative

Electronic Statements (e-Statements): By completing this consent agreement, you agree to permit Family Dentistry to make disclosures and provide notices to you in electronic form, including text/email; Instead of providing such notices and disclosures in printed form. You have the right to receive a printed account statement sent to your mailing address of record. By entering into this agreement, you understand that Family Dentistry will cease providing you with a printed statement in the mail, and that all future account statements will be sent by text or email.

Appointments: Times are reserved specifically to meet your needs. If for any reason you are unable to keep your reserved appointment time, a 24-hour advance notice is required by speaking directly with the front office (no texts) to avoid being charged. Since the office is closed on the weekends, all Monday appointments must be canceled by Friday at 12:00. Broken Appointment fees vary between $25.00 to $175.00.

Signature: _____ **Date:** ____/____/_____