

PATIENT NAME _____

DATE _____

Primary reason for this dental appointment: Examination Emergency Consultation

Dental History

Please Circle

Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations on a routine basis? Last visit _____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? Discuss _____ Yes No
Do your gums ever bleed? Discuss _____ Yes No
Do you like your smile? Why? _____ Yes No
Does food catch between your teeth? Any loose teeth? _____ Yes No
Do you want to keep your remaining teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
Have your past experiences in a dental office always been positive? _____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Yes No
Name of previous dentist (optional): _____
Date of last full mouth x-rays (16 small films or panoramic): _____

Medical History

Are you under a physician's care now? Why? _____ Who? _____ Phone _____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What? _____ Yes No
Are you on a special diet? Discuss _____ Yes No
Are you allergic to any medications or substances? Please check box below _____ Yes No
 Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Milk Other _____
Women (Please check): Pregnant/trying to get pregnant Nursing Taking oral contraceptives Discuss _____ Yes No

Do you now have or have you ever had any of the following? Do you take any of these medicines? Please check appropriate boxes.
*If yes to any of the starred conditions, please call prior to your appointment... premedication or changes in medication may be required.

Table with 4 columns of conditions (Yes/No) and 4 columns of medicines (Yes/No). Includes conditions like Heart Disease/Surgery, Excessive Bleeding, Chemotherapy, Night Sweats, etc.

Have you ever had any other serious illness not checked above? Discuss _____ Yes No
Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____ BP _____ Pulse _____

History Review and Significant Findings _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

Table with columns: DATE, EXCEPTIONS, PATIENT'S SIGNATURE, BP, PULSE, REVIEWED BY. Includes 'None' checkboxes for each row.

PATIENT INFORMATION

DATE _____

NAME _____ MARRIED SINGLE MINOR MALE FEMALE
LAST FIRST M

SOCIAL SECURITY # _____

ADDRESS _____
STREET APT. # CITY STATE ZIPBIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME WORK CELL E-MAIL

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: PATIENT GUARDIAN SPOUSE FATHER MOTHER**INSURANCE INFORMATION**MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS - COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY				SECONDARY INSURED			
LAST	FIRST	M		LAST	FIRST	M	
STREET	CITY	STATE	ZIP	STREET	CITY	STATE	ZIP
HOME	WORK	CELL	E-MAIL	HOME	WORK	CELL	E-MAIL
BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT		BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT	
EMPLOYER		DENTAL INS. CO		EMPLOYER		DENTAL INS. CO	
SS#	SUBSCRIBER #	GROUP #		SS#	SUBSCRIBER #	GROUP #	

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

Has any member of your family ever been treated in our office?

 Yes NoWhom may we thank for referring you to our office?
_____**METHOD OF PAYMENT**

Responsible party currently has an account with this office

 Yes No Payment in full at each appointment (cash or personal check) Payment in full at each appointment (VISA MC OTHER)

Card # _____ Exp. Date _____

 I wish to discuss the Dental Office's Financial Policy**SERVICE CHARGE**If I do not pay the entire new balance within 30 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5 % per month (or a minimum charge of \$5.00 for a balance under \$335) which is an annual percentage rate of 18 % applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.**AUTHORIZATION**

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

X _____
Patient or Responsible Party

Date _____ State Driver's License # _____

Three Fountains Family Dental, Inc.

Updates and Changes

It is the patients' responsibility to inform us at each appointment of any changes in medical history and/or medications. Please also inform us of any insurance, address and phone number changes at your appointments.

Appointment Policy

Our office will make every effort to confirm your appointment. If we cannot confirm your appointment, we reserve the right to reschedule your appointment. It is very important to return our calls when we are confirming your appointment. If you need to reschedule your appointment with our office, please give us twenty- four hours notice. Appointments cancelled without sufficient notice are subject to a \$30.00 cancellation fee

Insurance Policy

As a courtesy to our patients, after we have confirmed your dental insurance coverage our office will file your insurance claim directly to your insurance carrier. Keep in mind that any deductibles and co-payments are your responsibility and any co-payments quoted by our office are only estimates. Please understand that dental insurance is a contract between the patient and the insurance carrier, not between the insurance carrier and the dentist. Your employer has chosen the limits of your policy and every insurance policy is different. It is your responsibility to know the coverage and limitations of your policy. **Estimates quoted by our office are based on an average dental policy. In the event that your insurance carrier does not pay as much as we have estimated or does not pay your dental claim at all, you will be responsible for the balance due.** There are times when your insurance company will send you verification of insurance questionnaire. In that event please fill out any information they request, if this is not done your insurance company will withhold any payments and you, the patient, will be responsible for the balance.

Payment Policy

For your convenience, our office accepts Visa, MasterCard, Discover, personal checks and cash payments. Payment is due at the time services are rendered. Patients with confirmed dental coverage are required to pay all applicable deductibles and co-payments at the time services are rendered. There are no exceptions with this office policy. Crowns and dentures require an estimated 50% co-payment at the start of the service and the remaining balance prior to cementing of crowns or delivery of dentures. Any payments not received within 15 days of billing date are considered late and are subject to a 1.5 % late fee, as well as, responsible for any collection and legal fees.

Please read this office policy and sign below stating that you understand what the policy states. If you would like a copy of this we will be glad to give you one for your records.

Signature: _____ Date: _____

Three Fountains Family Dental, Inc.
**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

****You May Refuse to Sign This Acknowledgement****

I, _____, have received/reviewed a copy of this office's Notice of Privacy Practices.

{Please Print Name}

{Signature}

{Date}

List any person that may receive information on you and their relationship to you:

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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