Patient Information Form

Name_____ Date of birth_____
First MI Last

Address_____ City_____ State_____ Zip_____

Cell #_____ Soc Sec #_____ email_____

Check appropriate box □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated

Responsible Party (if patient is a minor) _____ phone #_____

Date of Birth: _____ Relationship to patient: _____ Driver's license #_____

Person to contact in case of emergency_____ phone #_____

Patient or Parent's employer_____ work phone #_____

Whom may we thank for referring you? _____

Dental Insurance Information

Name of Insured_____ relationship to patient_____

Date of birth_____ Soc Sec #_____ ID #_____

Employer name_____ Group #_____

Insurance Company_____ Phone #_____

×_____ _____
Signature of patient (or parent if minor) Date

Policy For Broken Appointments

Our number one concern is our patients' dental health. We value you as our patient and we value your time as we know you value ours. We understand that emergency situations and illness occur that may require you reschedule your appointment.

We require a minimum of 48 hours (2 business days) to cancel an appointment.

Changes to scheduled appointments without **24 hours (2 business days) notice** may result in you being charged a **broke appointment fee of $35.00 per hour of scheduled treatment.** We do not accept messages left with our after-hours answering service to cancel scheduled appointments.

This policy is our attempt to ensure that both you and our other patients receive the highest quality of care that we are committed to provide.

×_____ _____

Signature of patient (or parent if minor) Date

Financial Responsibility Policy

NOTIFICATION OF FINANCIAL RESPONSIBILITIES:

All patients are financially responsible for the payment of services rendered by Medina Family Dental. Payment is expected at the time of service unless arrangements are made prior to your appointment. These payments include insurance co-pays, deductibles, and coinsurance. You are also responsible for any amount not paid by your insurance.

If timely payment is not made, interest will begin to accumulate after 90 days. An 12% interest rate will be added to the past due balance. After 120 days, your account will be sent to a collections agency and there will be a 30% collection fee added to your existing balance.

Returned checks will result in a $35.00 charge to your account.

STATEMENT OF FINANCIAL RESPONSIBILITY:

I have carefully read and understand that I _____, am financially responsible for payment of all charges pertaining to services rendered by Medina Family Dental.

GUARANTEE OF PAYMENT:

Please initial below:

_____ I understand that I am totally responsible for payment of all fees and services rendered, irrespective of insurance coverage or other responsibilities.

_____ I have been advised that if my dental insurance company claims that services I received are not considered reasonable or necessary, I am responsible for payment of these services.

_____ I understand that if my dental insurance company deems services that I receive as “not a covered benefit”, I am responsible for payment of these services.

NOTE: The guarantor of each patient account is ultimately responsible for payment in full.

×_____ _____

Signature of patient (or parent if minor) Date

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of this notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

> Protected health information may be disclosed or used for treatment, payment, or healthcare operations. The practice reserves the right to change the privacy as allowed by law. The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions. The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

May we discuss your treatment, financial, and/or insurance with any member of your family? YES NO

If YES, please name the person(s) allowed to receive this information: _____

× _____ _____ _____

Signature of patient (or parent if minor) Print Patient Name Date

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
- ☐ communication barriers prohibited obtaining the acknowledgement
- ☐ Emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

Name _____ Date of Birth _____ Age _____

PATIENT MEDICAL HISTORY **Yes No**

1. Are you under medical treatment? ..... ☐ ☐

_____

2. Have you ever been hospitalized for
Any surgeries or serious illness?..... ☐ ☐

_____

3. Are you taking any medication(s) including
Non-prescription medications? ..... ☐ ☐

If yes, please list medication(s) below.

4. Do you smoke? _____ Do you use spit tobacco?_____..... ☐ ☐

5. Do you use alcohol _____ recreational drugs?_____..... ☐ ☐

6. Have you ever taken prescription diet drugs?..... ☐ ☐

If yes, what? _____

7. **Are you allergic to or have had any reactions to the following?** **Yes No**

Local Anesthetics (e.g., Novocaine) ..... ☐ ☐
Penicillin or other antibiotics..... ☐ ☐
Sulfa Drugs..... ☐ ☐
Barbiturates..... ☐ ☐
Sedatives..... ☐ ☐
Iodine..... ☐ ☐
Aspirin..... ☐ ☐
Codeine..... ☐ ☐
Latex..... ☐ ☐
Other..... ☐ ☐
If yes, please list_____

MEDICATIONS: _____

_____

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8. Do you have, or have you had any of the following?

	Yes No		Yes No		Yes No
Mitral Valve Prolapse	☐ ☐	Emphysema	☐ ☐	Stomach Problems/Ulcers	☐ ☐
Heart Murmur	☐ ☐	Asthma	☐ ☐	Epilepsy/Convulsions	☐ ☐
Heart Disease	☐ ☐	Respiratory Problems	☐ ☐	Fainting/Seizures	☐
Cardiac Pacemaker	☐ ☐	Hay Fever / Allergies	☐ ☐	Sexually Transmitted Disease	☐ ☐
Heart Attack	☐ ☐	Glaucoma	☐ ☐	AIDS or HIV Infection	☐ ☐
Angina / Chest Pain	☐ ☐	Anemia	☐ ☐	Tuberculosis	☐ ☐
High Blood Pressure	☐ ☐	Diabetes	☐ ☐	Swollen Ankles	☐ ☐
Low Blood Pressure	☐ ☐	Rheumatic Fever	☐ ☐	Thyroid Problems	☐ ☐
Joint Replacement	☐ ☐	Cancer	☐ ☐	Arthritis	☐ ☐
(Hips, Knees, etc)_____		Radiation Treatment	☐ ☐	Recent Weight Loss	☐ ☐
Stroke	☐ ☐	Sleep Apnea/CPAP	☐ ☐	Hepatitis/Jaundice	☐ ☐
Liver Disease	☐ ☐	Kidney Disease	☐ ☐	Other	☐ ☐
Leukemia	☐ ☐	Take Blood Thinner	☐ ☐	if yes, please list_____	

Authorization and Release

I have read and understand the above information. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I request and authorize the dentist and/or dental staff to perform necessary dental services which are deemed advisable.

X_____ Date:_____
(Patient Signature)

Minor/Child Consent

I _____, the parent/guardian of _____, request and authorize the dentist and/or dental staff to perform necessary dental services which are deemed advisable.

_____ Date: _____
(Signature of Parent/Guardian)

_____
RDH Initials/Date

Patient Dental History

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot / cold?	☐	☐
3. Are your teeth sensitive to sweet / sour?	☐	☐
4. Do you feel pain in any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Do you have any head, neck, or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
a. clicking	☐	☐
b. pain (joint, ear, side of face)	☐	☐
c. difficulty in opening or closing	☐	☐
d. difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you had any difficult extractions in the past?	☐	☐
12. Have you had any orthodontic (braces) treatment?	☐	☐
13. Have you ever had any prolonged bleeding following extractions?	☐	☐
14. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
15. Have you ever had instruction on the care of gums?	☐	☐
16. Do you frequently have dry mouth?	☐	☐

17. How many times a day do you brush your teeth? _____ floss?_____

Women Only	**Yes**	**No**
A. Are you pregnant or think you are pregnant?	☐	☐
B. Are you nursing?	☐	☐
C. Are you taking birth control pills?	☐	☐

STOP HERE BELOW FOR OFFICE USE ONLY

Medical History Update:

Has there been any change in your health since your last dental appointment. ☐ Yes ☐ No

If yes, please list?_____

Are you taking any new medications? ☐Yes ☐No If yes, please list _____

_____

_____ _____ _____ _____

Patient Signature Date Dr. Initials RDH Initials