Medical Alert:

PATIENT

REASON FOR TODAYS VISIT: _____

(PLEASE PRINT) Mr./Mrs./Ms. (Circle one) Male _____ Female _____

PATIENT NAME: FIRST _____ MI ____ LAST _____ DOB _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE (___)_____ WORK PHONE (___)_____ SSN #_____ -_____ -_____

E-MAIL _____ EMPLOYER _____

NAME OF PHYSICIAN & PHONE NO _____ DATE OF LAST PHYSICAL _____

IN CASE OF EMERGENCY CONTACT _____ ***PHONE*** _____

DO YOU HAVE A HISTORY OF:

	YES	NO		YES	NO		YES	NO		YES	NO
A.I.D.S/HIV Positive	❑	❑	Excessive Bleeding	❑	❑	Low Blood Pressure	❑	❑	Stroke	❑	❑
Alcoholism	❑	❑	Frequent Headaches	❑	❑	Malignancies	❑	❑	Tuberculosis	❑	❑
Allergies	❑	❑	Hearing Impaired	❑	❑	Neck & Back Problems	❑	❑	Ulcers	❑	❑
Anemia	❑	❑	Heart Disease	❑	❑	Nervous Problems	❑	❑	Venereal Disease	❑	❑
Arthritis	❑	❑	Heart Valve, Murmur	❑	❑	Pacemaker	❑	❑	Bone Disease	❑	❑
Asthma	❑	❑	Hepatitis/Liver Disease	❑	❑	Prosthetic Joints	❑	❑	Epilepsy	❑	❑
Cancer	❑	❑	Hepatitis Carrier	❑	❑	Psychiatric Care	❑	❑	Thyroid Disease	❑	❑
Chemical Dependency	❑	❑	High Blood Pressure	❑	❑	Radiation Treatments	❑	❑			
Chest Pain	❑	❑	Kidney Disease	❑	❑	Respiratory Problems	❑	❑	Are there any problems		
Circulatory Problems	❑	❑	Kidney Dialysis	❑	❑	Rheumatic Fever	❑	❑	not listed you would like		
Convulsions/Seizures	❑	❑	Latex Sensitivity	❑	❑	Scarlet Fever	❑	❑	to discuss?	❑	❑
Diabetes	❑	❑	Lupus	❑	❑	Sinus Problems	❑	❑			

List any medications you are taking including non-prescription drugs

1. _____
2. _____
3. _____
4. _____

Are you allergic to any medications?

1. _____
2. _____
3. _____
4. _____

DENTAL INFORMATION

1. Date of last dental visit: _____
2. If wearing dentures, age of dentures: _____

	YES	NO
3. Do your gums bleed when brushing or eating?	❑	❑
4. Do you ever clench or grind your teeth?	❑	❑
5. Are your teeth sensitive to hot, cold or pressure?	❑	❑

WOMEN	YES	NO
Is there a possibility of pregnancy?	❑	❑
Estimated delivery date ____/____/____	❑	❑
Are you nursing?	❑	❑
Are you taking birth control pills?	❑	❑

WOMEN NOTE: *Antibiotics (such as penicillin) may alter the effect of birth control pills. Consult your physician/gynocologist for assistance regarding additional methods of birth control*

On a scale of 1 to 10 with 10 being the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

If I could change my smile I would make my teeth:	YES	NO
Whiter	❑	❑
Straighter	❑	❑
Close space	❑	❑
Replace black mercury fillings with tooth colored restorations	❑	❑
Repair chipped teeth	❑	❑
Replace missing teeth	❑	❑
Less gum showing	❑	❑
Replace old crowns or caps that don't match	❑	❑
Do you prefer to save your teeth?	❑	❑

I certify that I have read and understand the questions above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff responsible for any errors that I have made in the completion of this form.

Signature of Patient (parent or guardian if minor): _____ Date _____

Health History Reviewed by: _____ Dentist Signature: _____

ACCOUNT INFORMATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

Guarantor's Name (Last – First – Middle)	Date of Birth	Martial Status S M D W	Today's Date
Address (Street) (City) (State) (Zip)		Home Phone ( )	
Name of Employer	Occupation	Work Phone ( )	(Ext.)
Employer Address (Street) (City) (State) (Zip)			Social Security No.
Spouse's Name (Last – First – Middle)	Date of Birth	Name of Employer	Work Phone ( ) (Ext.)
Dependent(s) Name (Last – First – Middle)	Date of Birth	Social Security No.	Home Phone
Name:			( )
Name:			( )
Name:			( )
Dependent(s) Address (if different) (Street) (City) (Zip)			
Whom May We Thank for Referring You to Us?	E-Mail Address (For Appointment Confirmation & Specials in the future)		

INSURANCE INFORMATION

Primary Insurance Name	Address (Street – City – State – Zip)		Phone No. ( )
Name of Insured	Relationship	I.D. No.	Group No.
Secondary Insurance Name	Address (Street – City – State – Zip)		Phone No. ( )
Name of Insured	Relationship	I.D. No.	Group No.

I authorize and request my insurance company to pay directly to the dentist or dental group, insurance benefit otherwise payable to me. I understand that my dental insurance carrier may pay less than the amount due for services. I hereby agree to pay in full any amounts that are not paid by my insurance carrier within 90 days after services are rendered on my behalf or my dependents.

Signature _____ Date _____

FINANCIAL POLICY

Thank you for choosing Advance Family Dental Care as your health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment.

The person financially responsible for the *patients' account must* complete the Account Information on the reverse side before the patient sees the doctor.

- *FULL PAYMENT IS DUE AT THE TIME OF SERVICE*
- *We accept:*
  - *Cash*
  - *Checks*
  - *Visa and MasterCard.*

REGARDING INSURANCE:

- We require deductible and copays to be paid at the time of service.
- *Your insurance policy is a contract between you and your Insurance company* However, we will automatically bill your insurance company for services rendered as a courtesy to you.
- It your insurance company has not paid the total claim within 90 days from the date of your treatment, the balance will automatically be billed to you. Please be aware that we may receive only a partial amount of what was totally billed to your insurance company. You will be responsible for amounts the insurance company has determined as ineligible or not covered in full.
- If we cannot verify eligibility prior to treatment, you are expected *to* pay in full at the time of service. We will be glad to submit your insurance form and direct your insurance company to make payment directly to you.

USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MINOR PATIENTS:

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit card, or payment by cash or check at time of service has been verified.

MISSED APPOINTMENTS:

Unless cancelled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $30.00. Please help us serve you better by keeping scheduled appointments.

LATE FEES:

If your payment is not received on or prior to the due date on your statement, a late fee of $30.00 will be added to your account.

Thank you for understanding cur Financial Policy. Please let us know if you have any questions or concerns.

I have read and understand the Financial Policy.

--- ---

Signature of Responsible Party *Date*