WELCOME TO OUR PRACTICE

PATIENT INFORMATION

Last Name _____ First _____ MI____

Preferred Name_____ S.S. # _____

Birthday_____/_____/_____ Age _____ Gender: Male_____ Female _____

Family Status: Married _____ Single _____ Widowed _____ Child _____

Address_____

City_____ State _____ ZIP _____

Home Phone_____ Work Phone_____ Cell Phone_____

E-mail _____ How did you hear about us? _____

Emergency Contact _____ Phone _____

IF PATIENT IS UNDER 18 YEARS OF AGE FILL OUT THIS SECTION PERSON RESPONSIBLE FOR BILL / PAYMENT

Name _____Relationship to Patient _____

Address _____ City/State/Zip _____

Phone _____SS#_____/_____/_____ DL#_____

Employer Name: _____

Signature of parent or legal guardian _____

Today's Date_____

DENTAL INSURANCE INFORMATION

Primary Insurance Co._____ Phone #_____

Group #_____

Name of Subscriber_____ Birth Date _____/_____/_____

Subscriber's Social Security_____/_____/_____

Relationship to Patient_____

Employer_____

Secondary Insurance Co._____ Phone# _____

Group # _____

Name of Subscriber_____ Birth Date _____/_____/_____

Subscriber's Social Security_____/_____/_____

Relationship to Patient_____

Employer_____

☐ **By checking this box,**

I authorize my insurance company to pay Family & Cosmetic Dentistry all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.
I also understand that it is not Family & Cosmetic Dentistry responsibility to ensure that your insurance pays.

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (which includes but is not limited to the following; account information, appointment information and clinical information) to the secured website for the dental practice. I understand that for security purposes, the site requires a user ID and password for access and use.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf; in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the website on my behalf.

I have read the information above regarding the secured uploading of patient information to the website for the dental practice, and grant the dental practice permission to securely upload my patient information to the website.

SIGNATURE_____**DATE**_____

I authorize Family & Cosmetic Dentistry to contact me by the following:

☐ **Home Phone**

☐ **Work Phone**

☐ **Cell Phone**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.
I understand that at any time, this authorization may be revoked, when this office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.
I understand that information used or disclosed, pursuant to this authorization, could be subjected to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Signature: _____

Print Name: _____

Date: _____

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit all collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate (treatment plans) for this dental care can only be extended for a period of six months from the date of the patient examination unless otherwise noted.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, unless previous payment arrangements have been established.
I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all collection costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

I further authorize you or your assignee to discuss my treatment or financial obligations with the following listed person(s)

1. _____ 2. _____

SIGNATURE_____ **DATE**_____

I hereby authorize the following person(s) to bring my minor child to the office for treatment and give them the Authority to make dental treatment decisions regarding my child.

Name: _____ **Relationship:** _____
Name: _____ **Relationship:** _____

Signature _____ **Date** _____

FAMILY & COSMETIC DENTISTRY

PATIENT MEDICAL HISTORY & UPDATE FORM

Name: _____ Date: _____
Address: _____ City, State, and Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____

What is the best way to reach you in case of an emergency? _____

EMERGENCY CONTACT NAME: _____
EMERGENCY CONTACT NUMBER: _____

PRIMARY CARE PHYSICIAN NAME: _____
PCP PHONE: _____
PHARMACY NAME: _____
PHARMACY PHONE: _____

Please circle all those that apply:

Yes No	Conditions	Yes No		Yes No	
Yes No	Alzheimer	Yes No	HIV+ AIDS	Yes No	Thyroid Problems
Yes No	Anemia	Yes No	Head/Neck Injury	Yes No	Tonsillitis
Yes No	Arthritis	Yes No	Headaches	Yes No	Tuberculosis
Yes No	Artificial Bones/Joints	Yes No	Heart Murmur	Yes No	Ulcers
Yes No	Artificial Heart Valve	Yes No	Heart Problems	Yes No	Venereal Disease
Yes No	Asthma	Yes No	Hemophilia		
Yes No	Autism	Yes No	Hepatitis		
Yes No	Back Problems	Yes No	High Blood Pressure		
Yes No	Bleeding/Clotting Problems	Yes No	Jaw Pain		
Yes No	Blood Disease	Yes No	Kidney Problems		
Yes No	Blood Transfusion	Yes No	Liver Disease		
Yes No	Cancer- Chemotherapy	Yes No	Mitral Valve Prolapse		
Yes No	Circulatory Problems	Yes No	Nervous Problems		
Yes No	C.O.P.D.	Yes No	Pacemaker		
Yes No	Cold Sores	Yes No	Psychiatric Problems		
Yes No	Cough Up Blood	Yes No	Radiation Therapy		
Yes No	Cough, Persistent	Yes No	Rheumatic Fever		
Yes No	Developmental Disorders	Yes No	Scarlet Fever		
Yes No	Diabetes	Yes No	Shortness Of Breath		
Yes No	Epilepsy	Yes No	Sinus Problems		
Yes No	Fainting Spells	Yes No	Steroid Treatments		
Yes No	Glaucoma	Yes No	Stroke		
		Yes No	Swollen Feet/Ankles		

Yes No	Allergies
Yes No	Aspirin
Yes No	Codeine
Yes No	Dental Anesthetics
Yes No	Erythromycin
Yes No	Jewelry
Yes No	Latex
Yes No	Metals
Yes No	Penicillin
Yes No	Tetracycline

Other

_____
_____
_____

Do you smoke or use tobacco? Yes No

Women Only

Are you taking Birth Control?

YES NO

Are you pregnant?

YES NO

If yes, how many weeks?

_____

Are you nursing?

YES NO

PLEASE LIST ALL CURRENT MEDICATIONS & DOSAGES:

Have you had any serious illnesses or operations in the last 5 years? YES NO If yes, please describe:

Signature: Date:

OFFICE USE ONLY:

PREMED:_____
_____
_____
_____

SCRIPT: _____
_____
_____
_____