Patient Information

First:_____MI:___Last:_____ Preferred Name: _____ Gender: (circle) M F

Patient Birth Date: _____ Patient Social Security #: _____ Email Address: _____

Mailing Address:_____City:_____St:_____ Zip:_____

Phone:_____(cell/home) Work Phone:_____ Ext:_____ Employer: _____

Emergency Contact: _____Relationship: _____ Phone #: _____

Responsible Party - The following is: □ the patient's spouse □ the person responsible for payment

Name: _____ Birth Date:_____ Responsible Party SS#_____

Address: _____ Phone:_____ Employer: _____

Dental & Health Information

Do you have history of any of the following? Please check those that apply:

□ AIDS or HIV
□ Alcohol Abuse
□ Allergies
□ Anemia
□ Angina
□ Arthritis
□ Asthma
□ Bleeding Disorder
□ Blood Disease
□ Cancer
□ Chronic Cough w/blood
□ Dental Anxiety
□ Diabetes
□ Dialysis
□ Dizziness
□ Drug Abuse
□ Emphysema
□ Epilepsy

□ Excessive Bleeding
□ Fainting
□ Glaucoma
□ Head Injuries
□ Heart Disease
□ Heart Attack
□ Heart Murmur
□ Hepatitis (Type_____)
□ High Blood Pressure
□ High Cholesterol
□ Jaundice
□ Kidney Disease
□ Leukemia
□ Liver Disease
□ Low Blood Pressure
□ Mitral Valve Prolapse
□ Nervous Disorders
□ Pacemaker

□ Psychiatric Problems
□ Radiation Treatment
□ Respiratory Problems
□ Rheumatic Fever
□ Sexually Transmitted Disease
□ Seizures
□ Sinus Problems
□ Stomach Problems
□ Stroke
□ Thyroid Problem
□ Tuberculosis (TB)
□ Tumors
□ Ulcers
□ Smoke
□ Use Tobacco
□ Any type of Implant
□ Any type of Transplant
□ Any Artificial Joint *(knee, shoulder, hip, etc.)*

Women

□ Currently pregnant
If yes, # of weeks:_____
□ Nursing?
□ Taking Birth Control?
Note: Antibiotics may alter the effectiveness of birth control pills.

Are you Allergic to any of the following?

□ Aspirin □ Codeine
□ Dental Anesthetics
□ Erythromycin □ Sulfa
□ Latex □ Metals
□ Penicillin □ Tetracycline
□ Other:_____

Reason for this Visit: _____

How did you hear about our office? _____ Date of Last Dental Visit:_____

- Is your general health good? □ **Yes** □ **No** - Are you currently taking **ANY** blood thinners or Aspirin □ **Yes** □ **No**
- Have you been told by a doctor that you should be pre-medicated for dental treatment? □ **Yes** □ **No**
- Have you ever had any complications during or following dental treatment? □ **Yes** □ **No**
  If yes, please explain: _____
- Are you currently taking any medications? Please list: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? □ **Yes** □ **No**
  If yes, please explain:_____
- Are you now under the care of a physician? □ **Yes** □ **No** *Name of Physician:_____
  If yes, please explain:_____
- Is there any other information which we should know about your heath? □ **Yes** □ **No** _____

I certify that I have read and understand the above questions and acknowledge that the questions have been answered to the best of my knowledge.

Patient's Signature _____Date _____

HIPAA PRIVACY POLICY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I,_____have been informed of, and given the right to review and secure a copy of this office's Notice of Privacy Practices. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20____.

Relationship to Patient: _____ Signature: _____

APPOINTMENT POLICY

We value your time so you can expect us to see you at the appointed time and to keep your time spent in our office as short as possible. In return, when you make an appointment with us please be on time since we have reserved our time just for you. Please make every effort not to change your scheduled appointment. If you must change an appointment, please provide us at least **2 working days advanced notification** to avoid a **$50 cancelation fee** and allow us to use our time to accommodate other patients. Broken and missed appointments create scheduling problems for other patients and our practice. *We value your time, please value ours!*

FINANCIAL POLICY

Unless another financial option is PRE-ARRANGED, payment in full is due the day of treatment. Should a patient have dental insurance with assignment to Farmington Family Dentistry, the ***estimated*** patient portion will be the amount due. If your insurance does not pay the amount we estimated, the remaining balance is the patient or Guarantor's responsibility. Insurance payments without assignment will be sent to the insured with payment due in full at the time service is rendered.

Payment Options

1. For your convenience we accept Cash, Check, Visa, Mastercard, Discover, American Express and Debit
2. We also offer short and long-term financing options. On approved credit. (Interest-free options may apply)

For Patients with Dental Insurance

PLEASE UNDERSTAND that we file dental insurance as a courtesy to our patients. We do not have a contract with your insurance company, only you do. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist you in ESTIMATING your portion of the cost of treatment; we at no time guarantee what your insurance will or will not do with each claim. By law your insurance company is required to pay each claim within 30 days of receipt. You are responsible for any balance on your account after 30 days, whether insurance has paid or not. Dental insurance plans often pay less than the actual fee for service, therefore the patient or Guarantor is the responsible party for all dental services provided. Dental insurance in most cases is a benefit with limitations and should not be expected to take care of all costs. The percentage paid is determined by how much you or your employer has paid for coverage or the type of contract your employer has set up with the insurance company. Insurance companies set their own fee schedules and each company uses a different set of fees they consider allowable. If our office is a preferred provider with your Insurance Company we will charge you the allowed fee. Our office does not accept "Assignment of Benefits" for secondary insurance, with exception of some federal dental plans. We will file your primary insurance and be happy to help you with filing your secondary insurance.

Finance Charge and Fees

- Balances in excess of 90 days are subject to a finance charge of 1.5% per month, each month until balance is paid. (18% annual)
- Returned checks are subject to a $35 accounting fee.

AUTHORIZATION AND CONSENT

- I agree and consent to a dental examination by Farmington Family Dentistry. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed. I understand that the fee estimate listed on the Treatment Plan for dental care can only be extended for a period of six (6) months from date of the patient examination.

Release of Information

I authorize Farmington Family Dentistry to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/ or other health professionals.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to Farmington Family Dentistry.
I understand and will comply with the Office Appointment Policy
I understand and will comply with the Office Financial Policy
I understand and agree to the General Consent to Treatment
I authorize the Release of Information

☐ Please check this box if you would allow us to **SEND APPOINTMENT REMINDERS VIA EMAIL AND/OR TEXT MESSAGES.**

We assure your confidentiality and your information will remain secure within our practice and not be shared with any third party.

X_____ Date_____

Signature of patient, parent or guardian