

Welcome

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

DATE:

PATIENT INFORMATION

Name:

Birth date:

SS#

Address:

City:

State:

Zip:

Email:

Cell Phone:

Home Phone:

Sex:

 M F Single Married Divorced Separated Widowed Partnered Minor

Who may we thank for referring you?

Employer/School:

Employer/School Phone:

Employer/School address:

City:

State:

Zip:

Spouse/Parent's Name:

Employer:

Phone:

Person to contact in case of emergency (and phone number):

RESPONSIBLE PARTY

Person responsible for this account:

Relation to patient:

Address:

City:

State:

Zip:

Birth date:

Best phone:

Work phone:

ext

Employer:

Current patient in our office?

 Yes No

INSURANCE INFORMATION

Name of policy holder:

Relation to patient:

Insured home address:

City:

State:

Birth date:

SS#

Zip Code:

Best Phone:

Employer:

Date Employed:

Insurance Company:

Group #

ID#

Deductible Amount:

Annual Maximum:

ADDITIONAL INSURANCE

Name of policy holder:

Relation to patient:

Insured home address:

City:

State:

Birth date:

SS#

Zip Code:

Best Phone:

Employer:

Date Employed:

Insurance Company:

Group#

ID#

Deductible Amount:

Annual Maximum:

DENTAL HISTORY

Reason for today's visit: Date of last dental care:
Former Dentist: Date of last dental X-rays:
Address: City: State:

Check if you have had problems with any of the following:

- Bad breath Grinding teeth Bleeding gums Food collection between the teeth
 Clicking or popping jaw Periodontal treatment Loose teeth or broken fillings Sores/growths
 Sensitivity to cold Sensitivity to hot Sensitivity to sweets Sensitivity when biting

How often do you floss? How often do you brush?

MEDICAL HISTORY

Physician's name: Date of last visit:
Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine). Yes No
Have you had any serious illnesses or operations? Yes No If yes, describe:
Have you ever had a blood transfusion? Yes No If yes, approximate date:
(For women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check if you have had any of the following:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough, persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints, Pins, etc. | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Swollen Feet/Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bleeding Anormally | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever | |

List all medications you are currently taking and correlating diagnosis:

Allergies:

PATIENT CONSENT FORM & FINANCIAL AGREEMENT

To the best of my knowledge, the information in my chart is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

David Roach Family Dentistry may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that my information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and I may contact this organization at any time at the above address to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment or health care operations. I also understand you are required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, though it does not forfeit its uses prior to that revocation.

I, , choose the following option for my dental care and for the care of my dependents.

Please check that which applies:

- I do not have dental insurance, and thus:
- As treatment progresses, at each appointment I elect to pay with: cash check credit card
 - I wish to apply for your in-office finance plan. I understand that on approved credit, I may pay half on the preparation date and the balance on the second appointment or commit to a payment plan.
 - I will be signing up for your Discount Savings Plan, or I already have it, and elect to adhere to its policies.
- I certify that I, and/or my dependent(s) have insurance coverage with ; and assign directly to David Roach Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I am contracted with the above insurance company(ies) to pay an insurance-specified co-payment at the time service is rendered. **I understand that I am financially responsible for all charges whether or not they are paid for by insurance.** I will pay any uninsured portions as treatment progresses.

We ask that you realize that we do NOT work for insurance companies and instead work **100%** for our patients.

Insurance can be a great benefit for many patients, and we will do everything in our power to ensure you get every benefit allotted in your insurance contract. However, the treatment we recommend and the fees we charge will always be based on your individual needs, not on your insurance coverage.

Please Note: Your scheduled appointments are reserved exclusively for you. We have a 48 hour cancellation policy in order to provide you with this personalized attention. We understand that circumstances may arise that require an appointment to be rescheduled. We are happy to change an appointment time if a 48 hour notice is given. **If sufficient notice is not given, we reserve the right to charge a \$50 missed appointment fee to your account.** We ask that you make every effort to keep your reserved time.

Patient Name:

Date:

Electronic Signature of Patient or Responsible Party:

Relationship to Patient: