

CONFIDENTIAL

Patient Information

Thank You for Choosing our Practice for your dental needs. Please Complete this form in ink.
If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name _____ Date _____
First MI Last
Social Security No. _____ Birthdate _____
Address _____ City, State Zip _____
Home Phone # _____ Work Phone # _____ Extention _____
Cell Phone # _____ Email: _____
Are you: Minor _____ Married _____ Divorced _____ Widowed _____
Single _____ Separated _____
Are you: Male _____ Female _____
You or Your Parent's employer _____ Occupation _____
Spouse's or Parent's Name _____ Work Place _____
Work # _____
City, State _____
Person to contact in case of Emergency : _____
Phone # _____

Responsible Party

Name of Person responsible for account? _____ Relationship to Patient _____
Phone # _____ Address _____
Name of Employer _____ Work # _____

Dental Insurance Information

Primary Carrier

Name of Insured _____ Relationship to Patient _____
Policy Holder Birthdate _____ Social Security # _____
Name of Employer _____ Work # _____
Insurance Company _____ Group # _____
Policy ID # _____ Insurance Co. Phone # _____

DO YOU HAVE ADDITIONAL INSURANCE? Yes _____ No _____
Name of Insured _____
Relationship to Patient _____ Birthdate _____
Social Security # _____
Name of Employer _____ Work # _____
Insurance Company _____ Group # _____
Policy ID # _____

I understand that responsibility for payment for Dental Services provided for myself or my dependents is mine, due and payable at the time services are rendered unless prior arrangements have been made.

Signature _____ Date _____

Patient Medical History

Please answer all questions & sign and date below:

Name: _____

PERSONAL HISTORY #1 -#7

1. Are you now under the care of a Physician? Yes / No

If so what are you being treated for? _____

Physician Name _____ Phone # _____

Physician Address _____

2. Are you taking any drug, medicine, or pills? (Prescription or over the counter) If so, what?

3. Are you being treated for Osteoporosis? Yes / No

4. Have you ever been told to be premedicated with an antibiotic before dental work? Yes / No

5. Have you had abnormal bleeding associated with previous extraction, surgery or trauma? Yes / No

6. Are you currently taking any Blood Thinners? Yes / No

Prescription Name: _____

7. Do you have or have you had any of the following diseases or Problems? **(INDIVIDUALLY CIRCLE YES OR NO)**

	Description	*Date / Type		Description
Yes / No	Artificial Heart Valve	*	Yes / No	Heart Murmur
Yes / No	Artificial Joint	*	Yes / No	Leaky Heart Valve
Yes / No	Heart Attack	*	Yes / No	Mitral Valve Prolapse
Yes / No	Heart Surgery	*	Yes / No	Epilepsy or Seizures
Yes / No	Pacemaker	*	Yes / No	High Blood Pressure
Yes / No	Other Heart Conditions		Yes / No	Low Blood Pressure
Yes / No	Diabetes (Type)	*	Yes / No	Stroke
Yes / No	Hepatitis		Yes / No	Tuberculosis (Active or Passive)
Yes / No	Radiation	*		Date TX Completed?
	Date of Last Treatment?		Yes / No	Hip or Joint Replacement
Yes / No	Pregnant		Yes / No	Kidney Disease
	Trimester?		Yes / No	Asthma
Yes / No	Chemotherapy	*	Yes / No	Back Problems
Yes / No	Organ Transplant		Yes / No	Chemical Dependency
	Organ Type ?		Yes / No	Fainting
Yes / No	Tobacco Habit		Yes / No	Jaw Pain
Yes / No	Positive to HIV (Aids)		Yes / No	Thyroid Disorder

8. Are you allergic or have you ever reacted adversely to:

Yes / No	Local Anesthetics	Yes / No	Iodine	Yes / No	Aspirin	Yes / No	Latex
Yes / No	Penicillin	Yes / No	Sulfa Drugs	Yes / No	Codeine		
Yes / No	Barbiturates	Yes / No	Erythromycin	Yes / No	Other Antibiotics		

Emergency Contact:

Name _____ Relationship _____

Phone # _____

To the best of my knowledge the above medical and dental history is correct. I hereby consent to such examinations and diagnostic procedures deemed necessary for dental treatment. I also authorize the doctor to perform any and all forms of treatment, medication and therapy.

Patient /Guardian Signature _____ Date _____

YANCEY DENTAL OFFICE

Request for Confidential Communication Protected Health Information (PHI)

Patient Name: _____

I give my permission for communications regarding my account and patient care shared with the following people/entities:

Name:	Relationship to Patient:
_____	_____
_____	_____
_____	_____
_____	_____

Our office requires positive confirmation concerning scheduling of appointments. May we have permission to leave messages on answering machines, cell phones, e-mails and contacts listed above?

Yes _____ No _____

Patient Name: _____

YANCEY DENTAL OFFICE

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I, _____ have received a copy of this office's
Notice of Privacy Practices.

Please Print Name

Signature

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

_____ An Emergency situation prevented us from obtaining.

_____ Communication barriers prohibited us from obtaining.

_____ Other _____

Practice Financial Policy

If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our official policy.

- Co-payments for office services are required at the time services are rendered.
- As a courtesy, we will process and file your insurance claims for services at no cost to you.
- For services that are covered by insurance, the practice requires payment of your deductible and your percentage of the total estimated charges.
- For services that are NOT covered by insurance, the practice requires 100% payment.
- Returned checks are subject to a handling fee of \$35. In the event your account must be turned over for collection, you will be billed and are responsible for all fees involved in that process.

You must realize that:

- Your insurance is a contract between you and your employer and/or the insurance company. While we may be a provider of services, we are not a party to that contract. We encourage you to contract your insurance carrier personally in order to remain informed of your benefits.
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover 100% or that they may consider unnecessary, and in some instance, you will be responsible for these amounts.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If you have questions about the above information or any uncertainty regarding your insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

PLEASE READ THE ABOVE CAREFULLY BEFORE SIGNING

Signature: _____ Date: _____

(Patient and/or Responsible Party)