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 # _____

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 # _____

If you are a student, name of School/college _____

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:

PERSONAL HISTORY

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? **(INDIVIDUALY CIRCLE EACH ONE 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 of Last Treatment?	*		Date TX Completed?
			Yes / No	Hip or Joint Replacement
Yes / No	Pregnant Trimester?		Yes / No	Kidney Disease
			Yes / No	Asthma
Yes / No	Chemotherapy	*	Yes / No	Back Problems
Yes / No	Organ Transplant Organ Type ?		Yes / No	Chemical Dependency
			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* _____

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 a payment 100% of total charges unless payment arrangements have been worked out.
- Returned checks are subject to a handling fee of $20.00. 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 instances, 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)

Patrick H. Yancey, III D.M.D

Request For Confidential Communication Protected Health Information

Patient Name:_____

I give my permission for communications regarding my account and patient care be directed in addition to myself to:

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:_____

Dr. Patrick H. Yancey III

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

___Communications barriers prohibited obtaining the acknowledgement

___An emergency situation prevented us from obtaining acknowledgement

___Other_____