Patient Information

Date:_____

Patient Name:_____Preferred Name:_____ Marital Status: S M D W Other

Date of Birth: _____ Social Sec #: _____

Spouse's Name: _____ If child, Parents Name:_____

Address: _____City: _____ State: _____ Zip:_____

Home Phone: _____ Cell:_____ Work Phone:_____

Email: _____ Name of Employer: _____

How would you prefer to be contacted, circle all that apply: Text Email Phone

How did you hear about our office?_____

Patient Health History

Primary Doctor: _____ Hospitalizations within the last year: _____

Circle any allergies you may have:

Aspirin Penicillin Codeine Sulfa Latex Peanuts Local Anesthetics

Other Allergies:_____

Do you take Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?

Yes No If yes, which one: _____

Please list all other medications:_____

Have you ever been told by your medical doctor you need to take an antibiotic premedication before your dental appointment?
Yes No

Do you use any form of tobacco? Yes No If yes, what kind?_____

AIDS/HIV	Yes	No	Heart Conditions	Yes	No
Artificial Joints	Yes	No	Hepatitis A, B, or C	Yes	No If yes, which_____
Blood Thinners	Yes	No	Herpes	Yes	No
Cancer	Yes	No	High Blood Pressure	Yes	No
Chemo/Radiation	Yes	No	Pacemaker	Yes	No
Diabetes	Yes	No	Pregnant	Yes No	Due date:_____

Do you have any other health issues:_____

Patient Insurance Information

Dental Insurance Provider: _____ Ins. Phone Number: _____

Insurance ID #: _____ Group #: _____

Is this insurance thru an Employer: Yes: _____ NO

Name of insured/employee: _____ Date of Birth:_____

Patients relationship to insured: Self Spouse Child Other

Financial Policies

Your estimated out-of-pocket expense is required at the time of service unless prior arrangements have been made. We accept Cash, Check, Debit Cards, Visa, MasterCard, Discover, Lending Club and Care Credit.

Once applicable insurance has paid, any remaining balance will be the responsibility of the patient due upon receipt of statement. Our office is committed to helping you maximize your insurance benefits. Because insurance policies vary, we can only estimate your coverage in good faith, but cannot guarantee coverage due to the complexities of insurance contracts. We recommend that all patients contact their insurance company to better understand their benefits and how claims will be processed. We will attempt to help you receive full insurance benefits; however, you are personally responsible for your account, and we encourage you to contact your insurance company if they have not paid within 30 days.

If the patient is a minor (18 years and younger), the parent or guardian is responsible for payment of the account, in accordance with the policies outlined herein.

Missed Appointment

Your scheduled appointment time has been reserved specifically for you. If you are unable to keep an appointment it is required that you notify our office (even after hours) at least 12 hours in advance. Two failures to notify us less than 12 hours before your appointment will require a deposit of $50 to reserve any future appointments. Deposits made will be used towards patients out of pocket portions on next visit.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This form is used to obtain acknowledgement of receipt of our Notice of Privacy
Practices, Financial Policies and Missed Appointment policies or to document our good faith effort to obtain that acknowledgement.

I, _____,have received a copy of Edward's Family Dentistry's Notice of Privacy Practices, Financial Policies and Missed appointment policies.

Signature of patient, parent, or guardian:_____Date:_____