DN FAMILY DENTAL CARE

Patient Information

Initial_____ Updated _____

Patient Name: _____ Date: _____
Last, First Mi (Preferred Name)

Gender: ☐Female ☐Male Family Status: ☐Minor ☐Married ☐Divorced ☐Windowed ☐Separated ☐Single

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

Phone(H):_____ (W):_____ (C):_____ (Other):_____

At which number would you like us to contact you? ☐Home ☐Work ☐Cell Phone ☐Other

Address: _____
Street Apt#.

_____
City State Zip Code

Responsible Party

Name of Person Responsible for this account: _____

Social Security#: _____ Birth Date: _____ Relationship to patient: _____

Gender: ☐Female ☐Male Family Status: ☐Married ☐Divorced ☐Windowed ☐Separated ☐Single

Phone(H)_____ (W)_____ Are you a patient in the office? _____Yes _____No

Address: _____
Street Apt#.

_____
City State Zip Code

Patient Medical History

Date of last medical Exam: _____ Name/Phone Number of Doctor: _____

Date of last dental visit: _____

	YES/NO
1.Are you under medical treatment now?	☐ ☐
2.Have you ever been hospitalized for any surgical operation or serious illness?	☐ ☐

3.Are you allergic to or have you had any reactions to the following?

YES/NO		YES/NO	
☐ ☐	Local anesthetics (Eg Novocaine)	☐ ☐	Barbiturates
☐ ☐	Penicillin or other antibiotics	☐ ☐	Sedatives
☐ ☐	Sulfa drugs	☐ ☐	Lodine
		☐ ☐	Aspirin
		☐ ☐	Others _____

	YES/NO
4. Are you taking any medication(s)? if yes, what medication(s) are you taking? _____	☐ ☐
5. Do you use Tabaco?	☐ ☐
6. Do you use alcohol, cocaine or other drugs?	☐ ☐
7. Are you wearing contact lenses?	☐ ☐
8.WOMEN ONLY: a) Are you pregnant or think you may be pregnant?	☐ ☐
b) Are you nursing?	☐ ☐
c) Are you taking birth control pills?	☐ ☐

Do you have or have you had any of the following?

YES/NO		YES/NO		YES/NO		YES/NO		YES/NO	
☐ ☐	High Blood Pressure	☐ ☐	Epilepsy / Convulsions	☐ ☐	Heart Disease	☐ ☐	Cancer	☐ ☐	Stomach Troubles /Ulcers
☐ ☐	Heart Attack	☐ ☐	Leukemia	☐ ☐	Cardiac Pacemaker	☐ ☐	Arthritis	☐ ☐	Chest Pains
☐ ☐	Rheumatic Fever	☐ ☐	Diabetes	☐ ☐	Heart Murmur	☐ ☐	Joint Replacement	☐ ☐	Stroke
☐ ☐	Swollen Ankles	☐ ☐	Kidney Diseases	☐ ☐	Angina	☐ ☐	plant	☐ ☐	Hay Fever/Allergies
☐ ☐	Fainting/Seizures	☐ ☐	AIDS or HIV infection	☐ ☐	Frequently Tired	☐ ☐	Hepatitis/Jaundice	☐ ☐	Tuberculosis
☐ ☐	Asthma	☐ ☐	Anemia	☐ ☐	Respiratory Problems	☐ ☐	Sexually Transmitte	☐ ☐	Radiation Therapy
☐ ☐	Low Blood Pressure	☐ ☐	Thyroid Problem	☐ ☐	Emphysema	☐ ☐	Disease	☐ ☐	Easily Winded
☐ ☐	Recent Weight Loss	☐ ☐	Liver Disease	☐ ☐	Glaucoma	☐ ☐	Heart Trouble	☐ ☐	Others_____

Patient Dental History

	YES/NO		YES/NO
1. Do you feel pain to any of your teeth?	☐ ☐	4. Have you had any orthodontic work?	☐ ☐
2. Do your gums bleed while brushing or flossing?	☐ ☐	5. Have you had any head, neck or jaw injuries?	☐ ☐
3. Are your teeth sensitive to hot or cold sweet or sour liquids/foods?	☐ ☐	6. Have you ever had difficult extraction or prolonged bleeding following extractions?	☐ ☐

Referral Information

Whom may we thank for referring you to our practice?

☐ A patient, friend / relative "Name of person: _____ ☐ Insurance
☐ Walking by ☐ Yellow pages
☐ Post Cards / other received by office representative ☐ Other: _____
☐ Internet

AUTHORIZATION

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

CONSENT

Consent for Services

I authorize the dental health professionals (Doctors and Staff)) of DN Family Dental Care to perform those procedures as deemed necessary or advisable to maintain my dental health, including arrangement and/or administration of any sedative, analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic, or surgical treatments. I understand that the administration of local anesthetic may cause an unpleasant reaction or side effects which may include, but are not limited to bruising, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. **Publication of Records:** I authorize photos, slides, x-rays or any other viewing of my care and treatment during or after its completion to be used for either the advancement of dentistry or in promotional materials. My identity will not be revealed to the general public.

Financial Policy:

Payment for all services rendered is due the day of service unless prior arrangements have been made.
The following financial arrangements are accepted for all services over $500:
-A book keeping courtesy of 6% will be extended when payment is made in full by cash or check before treatment begins.
- We offer 3, 6 or 12 month deferred interest payments with credit approval through an outside finance company. (Credit approval required).
-We offer extended financing up to 48 months with 12.96% interest rate through an outside finance company. (Credit approval is required).
-Payments can be made during the course of treatment. 1/3 of the total case fee is due to secure the appointment, 1/3 during treatment and 1/3 before completion.

Dental Insurance:

Our estimates regarding your dental insurance a given as carefully as possible. These estimated are based on information currently available and past history of any specific insurance company. However, your insurance carrier will ultimately decide on the benefit to be released. Our financial arrangement with you will include your estimated dental insurance but you are responsible for ALL treatment fees.

Acknowledgement

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Privacy Notice

We are required to provide you with a copy of our practices written policy on privacy. The notice provides in detail the use and disclosures of your protected health information that may be made by this practice, your individual rights, how you may exercise these rights, and the practice's legal duties with respect to your information. I was given the opportunity to read the Notice of Privacy Practices. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

To Our Valued Patient Letter

I have received the "To our Value Patient Letter". The letter contains information about the office policy.
X _____ Date: _____ Relationship to patient: _____
Signature of patient, parent or guardian

Language

What language do you speak? ☐ English ☐ Spanish ☐ Other _____
Do you need an interpreter? ☐ Yes ☐ No Who completed this form: _____
Relationship to patient: _____