



# PATIENT MEDICAL HISTORY

Dental health is important to one's overall health. To responsibly address your dental concerns, we need basic information regarding your health. Please answer the following questions:

**Please list the medications you are taking:**

**Are you allergic to:**

	YES	NO
Any antibiotics/medications.....	<input type="checkbox"/>	<input type="checkbox"/>
Please list: _____		
Latex.....	<input type="checkbox"/>	<input type="checkbox"/>
Jewelry Metals (Nickel etc).....	<input type="checkbox"/>	<input type="checkbox"/>

**Have you ever had:**

	YES	NO	Approximate Date:
A Heart Transplant.....	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___
A Heart Valve Replacement/Repair Surgery.....	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___
A Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___
Artificial Joint Surgery.....	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___
An Organ Transplant.....	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___
Cancer Treatment-Radiation/Chemotherapy/Surgery.....	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___
A Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___
High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___
Hepatitis or Liver Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___
Tuberculosis .....	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___
Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___
A Pacemaker .....	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___
AIDS/HIV .....	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___
Is there any special medical condition we should know about? _____			

**For women only:**

	YES	NO
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Congratulations!! Due Date: _____		
Are you nursing?.....	<input type="checkbox"/>	<input type="checkbox"/>

**Are you addicted to:**

	YES	NO
Tobacco Smoke.....	<input type="checkbox"/>	<input type="checkbox"/>
Chewing Tobacco.....	<input type="checkbox"/>	<input type="checkbox"/>
Narcotics.....	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol.....	<input type="checkbox"/>	<input type="checkbox"/>

**Dental questions, please explain:**

When, approximately, was your last dental visit? \_\_\_\_\_

Do your gums bleed? \_\_\_\_\_

Do you have sensitive teeth? \_\_\_\_\_

Do you get headaches? \_\_\_\_\_

If you could change anything about your smile, what would you change?

\_\_\_\_\_

What's the most important thing that you expect of your dentist?

\_\_\_\_\_

My signature and date below confirm that this health questionnaire is accurate to the best of my knowledge.  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Patient Consent Form

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 this 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 physician 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 that I may contact this organization at any time at the address below 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 or disclosed to carry out treatment, payment or health care operations. I also understand you are not 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, except to the extent that you have taken action relying on this consent.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

# Fountain View Family Dental

## Our Financial Policy

Thank you for choosing Fountain View Family Dental as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we ask that you read and sign prior to your treatment today.

**Full payment/co-payment is expected at time of service. Additional appointments will not be made whenever a balance is carried on your account.**

We accept Visa, MasterCard, and customized payment plans through Care Credit for your convenience.

### *Regarding Insurance*

As a courtesy to you, we will be happy to submit your insurance claim. We accept most insurances and participate with Delta Dental and Blue Cross/Blue Shield. Please inquire with our office staff in regards to any other questions you may have regarding your individual policy. We require the appropriate payment or co-payment at the time of service depending on which insurance carrier you have. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We cultivate good relationships with insurance companies to maximize your hard earned benefits. **If your insurance claim has not been paid in 45 days, we require that you pay the balance in full.**

### *Usual and Customary Rates*

Our practice is committed to providing the best and most appropriate treatment for our patients. In some instances, multiple treatment options will be presented. You are responsible for payment regardless if any insurance company's arbitrary determination of usual and customary rates.

### *Interest*

We reserve the right to charge interest in the amount of 1.5% (18%APR) as provided by state law on unpaid balances.

We work hard at Fountain View to keep our fees affordable for our patients. We encourage second opinions especially with complex cases. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy:

\_\_\_\_\_  
Signature of Patient or Responsible Party

Date: \_\_\_\_\_