PATIENT INFORMATION FORM (CONFIDENTIAL)

Name _____ Date_____
First MI Last
Preferred Name or Nickname_____
Address _____
City _____ State _____ Zip Code _____
Phone (Home) _____ (Cell) _____ (Work) _____
Email _____
SS# _____ Birth Date _____
Male __ Female__ Married ___ Divorced ___ Single ____ Minor ___ Other____

Whom may we thank for referring you or how did you hear about us?_____

Phonebook___ TV____ Internet___ Radio(list station)_____ Other_____

RESPONSIBLE PARTY (If patient is a minor)

Guarantor _____ Relationship to Patient _____
Address _____ Phone _____
Birth Date _____ SS# _____
Employer _____Work Phone _____
Is this person currently a patient in our office? ____ Yes ____ No

PRIMARY DENTAL INSURANCE INFORMATION

Insured _____ Relationship to Patient _____
Birth Date _____ SS# _____
Employer _____ Work Phone _____
Employer Address _____
City _____ State _____ Zip Code _____
Insurance Co. _____Tel. # _____
Group # _____ ID# _____
Insurance Address _____
City _____ State _____ Zip Code _____

SECONDARY DENTAL INSURANCE INFORMATION

Insured _____ Relationship to Patient _____
Birth Date _____ SS# _____
Employer _____ Work Phone _____
Employer Address _____
City _____ State _____ Zip Code _____
Insurance Co. _____Tel. # _____
Group # _____ ID# _____
Insurance Address _____
City _____ State _____ Zip Code _____

X _____
Signature of Patient or Parent/Guardian if Minor

OVER →

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	☐	☐
Please list: _____		
Latex	☐	☐
Jewelry Metals (Nickel etc)	☐	☐

Have you ever had:	**YES**	**NO**	**Approximate Date:**
A Heart Transplant	☐	☐	___ / ___ / ___
A Heart Valve Replacement/Repair Surgery	☐	☐	___ / ___ / ___
A Heart Attack	☐	☐	___ / ___ / ___
Artificial Joint Surgery	☐	☐	___ / ___ / ___
An Organ Transplant	☐	☐	___ / ___ / ___
Cancer Treatment-Radiation/Chemotherapy/Surgery	☐	☐	___ / ___ / ___
A Stroke	☐	☐	___ / ___ / ___
High Blood Pressure	☐	☐	___ / ___ / ___
Hepatitis or Liver Disease	☐	☐	___ / ___ / ___
Tuberculosis	☐	☐	___ / ___ / ___
Diabetes	☐	☐	___ / ___ / ___
A Pacemaker	☐	☐	___ / ___ / ___
AIDS/HIV	☐	☐	___ / ___ / ___

Is there any special medical condition we should know about? _____

_____

For women only:	**YES**	**NO**
Are you pregnant?	☐	☐
Congratulations!! Due Date: _____		
Are you nursing?	☐	☐

Are you addicted to:	**YES**	**NO**
Tobacco Smoke	☐	☐
Chewing Tobacco	☐	☐
Narcotics	☐	☐
Alcohol	☐	☐

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 insurance and participate with Delta Dental. 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: