FAMILY DENTAL STATION

(PLEASE PRINT CLEARLY) **Date:**_____

PATIENT:_____**PREFERS:**_____
LAST, FIRST, MI

GENDER: ☐F ☐M **MARTIAL STATUS:** ☐SINGLE ☐MARRIED ☐OTHER **SOCIAL SECURITY:** _____

HOME PHONE: _____**CELL PHONE:** _____**WORK PHONE:** _____
WHAT PHONE NUMBER IS BEST TO GET A HOLD OF YOU DURING THE DAY? ☐HOME ☐CELL ☐WORK

IS IT OK TO SEND TEXT MESSAGES? ☐**YES** ☐**NO**

ADDRESS: _____**CITY**_____ **STATE**_____ **ZIP**_____

BIRTH DATE: _____**EMAIL:** _____

DRIVERS LICENSE: _____

How were you referred to our practice?

What is the most important thing to you about your dental visit today?

What are the most important things to you about your smile and dental heath?

Please check if any of the following problems apply to you:

☐ Sensitivity (hot, cold or sweets)	☐ Grinding or clenching teeth	☐ Teeth or fillings breaking
☐ Headaches or earaches	☐ Bleeding, swollen or irritated gums	☐ Bad Breath/Dry Mouth
☐ Neck Pain	☐ Loose, tipped or shifting teeth	☐ Other pain/discomfort:

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

☐ Dentures	How old are they?
☐ Partial Dentures	How old are they?
☐ Periodontal gum treatments	How long ago?

Please share the following approximate dates:

Your last cleaning
Your last oral cancer screening
Your last complete x-rays

Tobacco	Do you use tobacco?		☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
	☐ # of years	☐ Or year quit		

If you could change your smile, would you: (Please check all that apply)

☐ Make your teeth whiter	☐ Replace black metal fillings w/ white filling	☐ Replace old crowns that don't match
☐ Make your teeth straighter	☐ Repair chipped teeth	☐ Have a smile makeover
☐ Close spaces between teeth	☐ Replace missing teeth	☐ Other:

On a scale of 1 to 5, with 5 being the highest rating: (please circle the numbers that best applies)

How important is your dental health to you?	◯**1** ◯**2** ◯**3** ◯**4** ◯**5**
I want to keep my teeth and improve my smile, but have certain time and money concerns.	◯**1** ◯**2** ◯**3** ◯**4** ◯**5**

Full payments are due and payable on the day of your dental visit. Please indicate which payment options you prefer when paying for your dental services or which payment options you'd like to learn more about: (Please check all that apply) (subject to insurance requirements)

☐Cash (10% Discount) ☐Check ☐Major Credit Card ☐Care Credit Financing ☐Custom In-office Payment Plan to meet your needs

MEDICAL HEALTH HISTORY

PLEASE SELECT YES OR NO		
Are you taking any Medications	☐ Yes	☐ No
List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Drug:	Drug:	Drug:
Are any of these medications for bone density?	☐ Yes	☐ No
Are any of these medications blood thinners?	☐ Yes	☐ No
Allergies to medications, substances, anesthetic, latex, metals?	☐ Yes	☐ No
Allergy:	Allergy:	Allergy:
For Women Only: Do you suspect you may be pregnant?	☐ Yes	☐ No
Heart Health: Are you treated for or advised of Heart disease?	☐ Yes	☐ No
Pacemaker, artificial heart valve, heart murmur?	☐ Yes	☐ No
High Blood Pressure?	☐ Yes	☐ No
GENERAL		
Major Surgeries	☐ Yes	☐ No
Surgery:	Surgery:	Surgery
Do you have any artificial joint/prosthesis or hardware?	☐ Yes	☐ No
Are you a diabetic?	☐ Yes	☐ No
Have you ever had radiation treatment, chemotherapy?	☐ Yes	☐ No
Tuberculosis?	☐ Yes	☐ No
Do you have stomach problems? (ie: heartburn, acid reflux, GERD, etc.)	☐ Yes	☐ No
Inflammatory disease such as arthritis or rheumatism?	☐ Yes	☐ No
Do you have any kidney problems?	☐ Yes	☐ No
Do you have any liver problems?	☐ Yes	☐ No
Do you have asthma?	☐ Yes	☐ No
Do you or have you had any sexually transmitted diseases?	☐ Yes	☐ No
Anemia, leukemia. Etc.?	☐ Yes	☐ No
HIV/AIDS?	☐ Yes	☐ No
Do you test positive for Hepatitis?	☐ Yes	☐ No
Excessive bleeding after being cut or injured?	☐ Yes	☐ No
Have you ever received a blood transfusion?	☐ Yes	☐ No
Consume alcoholic beverages?	☐ Yes	☐ No
Do you habitually use controlled substances or have you in the past?	☐ Yes	☐ No
Do you have any health problems that need further clarification?	☐ Yes	☐ No
Please explain:		

I acknowledge the information in the Medical History to be correct and current.
I have received a copy of Family Dental Station's "**Our Commitments**" form. I have read and thoroughly understand all the statements on the form.

X_____ Date:_____ Relation to Patient:_____
Signature of patient, parent or guardian

_____
Printed Name of parent or guardian

Release & Financial Policies:

- Full payments for services are due and payable on the day of my dental visit when treatment is started.
- I understand that all dental services furnished are charged directly to me as the patient regardless of insurance.
- I accept responsibility for past due and unpaid balances including; fees, penalties, interest, court costs and retrieval/posting of credit report information.
- I understand that my dental benefit plan is a contract between me and my insurance company, **Family Dental Station** is not part of that contract.
- I understand that some necessary treatments are not covered benefits under some plans.
- As a courtesy: **Family Dental Station** will complete and mail my insurance claim forms.
- If your insurance does not accept assignment of benefits full payment will be collected day of appointment. Reimbursements are sent to these patients.
- I agree that if my insurance payment comes to **Family Dental Station** and leaves a balance, **Family Dental Station** may charge the remaining balance due to my credit card on file.
- This office has a 48-hour cancellation policy. If the cancellation is made after the 48-hour deadline, **Family Dental Station** reserves the right to charge me a fee for the lost time.
- If a refund is requested, there will be an 8 to 12 week processing timeframe before checks would be received.
- If I was formerly a patient of record with a different dentist, I agree to and understand that all future care will be provided by **Family Dental Station** and its providers and do not hold **Family Dental Station** responsible for any care provided before this date.
- **There will be a $50 penalty on all returned checks.**

I authorize the dentists and hygienists at **Family Dental Station** to perform diagnostic procedures and treatment as necessary for proper dental care. I authorize and consent to photos and images to be taken and displayed for marketing and/or learning purposes. I hereby authorize 'Assignment of Benefit' by my insurance carrier and the release of any information concerning my (or my family's) health care, advice and treatment provided for the purpose of evaluation. By signing below, I agree to continue accepting financial responsibility for any and all services provided. I also verify that all the information on this form is current and accurate.

x_____ My initial here acknowledges that, I understand Family Dental Station abides by the HIPPA Law and will protect the privacy of my personal information.

_____

Signature of patient, parent or guardian

_____

Printed Name

Emergency Contact Information:

x _____Initial (here for us to talk with this person about you and your account.)

Name: _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Address: _____ **City**_____ **State**_____ **Zip**_____

Relationship to patient: _____

Responsible Party: *(if different than patient)*

Name: _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Address: _____ **City**_____ **State**_____ **Zip**_____

Date of Birth: _____ **Social Security Number:** _____-____-_____

Driver's License Number: _____

Insurance Information

Employment: *(Of Responsible Party)*

Patient: _____

Company:_____

Address: _____ **City**_____ **State**_____ **Zip**_____

Phone: _____ **Occupation:** _____

Insurance Primary plan:

Insured's Name: _____ **Date of Birth:** _____

Group Name (employer) : _____ **Group or Account #** _____

Member ID Number: _____

Insurance Company Name: _____

Claims Address: _____ **City**_____ **State**_____ **Zip**_____

Claims Phone: _____

Insurance Secondary plan:

Insured's Name: _____ _____ **Date of Birth:** _____

Group Name (employer): _____ **Group or Account #** _____

Member ID Number: _____

Insurance Company Name: _____

Claims Address: _____ **City**_____ **State**_____ **Zip**_____

Claims Phone: _____

FAMILY DENTAL STATION

Our Commitments

We feel it is important to share a few policies of our practice with you. We have put them in writing because we live by them and request that our patients live by them as well. We ask that you read this thoroughly to become familiar with them, then sign and date to indicate that you understand and agree to comply with them.

COMMITMENT TO TREATMENT POLICY

We believe that all treatment begun should be completed. Incomplete treatment leads to problems, complications, further disease, and more expenses. Therefore, if a plan is agreed upon and started, it needs to be completed. Rest assured that we would never move forward with treatment without your consent.

COMMITMENT TO APPOINTMENT POLICY

We reserve time for each patient in our practice and rarely keep patients waiting. An appointment written in our schedule with your name on it is a bond of trust that we will be here to serve you and that you will be present for that appointment. Our answering machine does not accept appointment cancellations or changes. We must have mutual respect for each other's time.

COMMITMENT TO FINANCIAL AGREEMENT POLICY

We believe we have a responsibility to you to use our best professional care, skill and judgment in planning and delivering your dental treatment. We can only fulfill this mission through a bond of trust with you to pay for services. We will do our best to make you aware of all fees before treatment is rendered

INSURANCE POLICY

Our office does not diagnose, render treatment or establish fees according to any insurance tables or allowances. Our fees are based on the care, skill and judgment of the professionals delivering the services, and the cost of operating a dental office dedicated to excellence. Please remember that we work 100% for you, not your insurance company. Your dental plan may only cover charges for the least expensive results. **We refuse to compromise our standards by offering anything less than the complete care that you deserve.** Please understand that you are ultimately responsible for any amounts not covered by your plan.

Thank you, we feel honored that you have chosen us to service your dental needs.