Dry Creek Family Dentistry

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Patient Information

PLEASE PRINT

NAME_____PREFERRED_____
ADDRESS_____CITY_____STATE_____ZIP_____
BIRTHDATE_____HOME PHONE_____
SS#_____CELL PHONE_____
CIRCLE ONE: minor single married divorced widowed separated
PARENT OR GUARDIAN NAME IF MINOR_____
RELATIONSHIP_____PHONE_____
IF PATIENT IS A STUDENT, NAME OF SCHOOL_____
WHOM MAY WE THANK FOR REFERRING YOU?_____
PERSON TO CONTACT IN AN EMERGENCY_____#_____
_____

Responsible Party

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____
RELATIONSHIP TO PATIENT_____PHONE_____
ADDRESS_____CITY_____STATE_____ZIP_____
DRIVER'S LICENSE #_____BIRTHDATE_____
EMPLOYER_____WORK PHONE_____
IS RESPONSIBLE PARTY CURRENTLY A PATIENT IN OUR OFFICE? yes no
_____

Dental Insurance Information

NAME OF INSURED_____BIRTHDATE_____
RELATIONSHIP TO PATIENT_____SUBSCRIBER ID_____
NAME OF EMPLOYER_____WORK PHONE_____
INSURANCE COMPANY_____GROUP ID_____
_____

To receive comprehensive treatment in this office, you should answer all questions on this history form. The questions asked relate directly to the safe and effective treatment you are to receive in our practice. To the best of your ability honest answers must be given. If you are unsure of the question, unsure of you answer, or whether the question relates to your medical condition, please discuss the matter with the doctor. ALL questions should be answered.

To properly evaluate your current health status it may be necessary for the dentist to contact your physician. Included on this form is "Permission to Release Information."

All information you supply to the office on this form and all information discussed during your interview by the dentist will always be held in the strictest confidence, and will not be disclosed to a third party without your permission.

Name, Address, and Telephone # of your primary care physician

_____

_____

Date of last visit to above doctor _____purpose_____
Do you suffer from any disability? _____ If yes, describe_____

_____

Have you ever, or do you now take illegal drugs? _____If yes, what drugs, and when taken

_____

Note: There are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and may be fatal.

Do you have AIDS, or are you HIV-positive? _____ If yes, describe and provide current status. _____
Do you now have, or have you ever had a venereal disease? _____ If yes, describe

_____

Have you ever had, or do you now have hepatitis? _____ If yes, describe _____

_____

For females: Are you pregnant?_____ Due date _____
For females: Are you taking birth control? _____ ***Note: There are drugs and medications used in routine dental care that decrease the effectiveness of birth control.***

Are you currently taking any drugs or medications? _____ If yes, please list and describe amounts and purpose.

_____

_____

_____

Note: There are many drug and medication incompatibilities, some of which may result in dangerous health problems. Information about your current use of medications and herbal supplements is essential.
Have you ever had an allergic reaction to any medications? _____ If yes, name of drug and describe. _____

Have you lost or gained weight recently? _____ If yes, describe _____

If you have ever been treated for any of the following, please circle and describe below.
Rheumatic Fever * Rheumatic Heart Disease * Heart Murmer * Congenital Heart Disease
Heart Trouble * Heart Attack * Angina * Heart Surgery * Pacemaker * Irregular Beats

_____

Stomach Disease * Intestinal Disease * Abnormal Bleeding * Excessive Bleeding * Anemia

_____

Breathing Problems * Asthma * Tuberculosis * Hay Fever _____

If you have ever been treated for any of the following, please circle and describe below.

Cancer * X-ray Treatments * Chemotherapy _____

_____

Diabetes * Kidney Problems * Renal Dialysis

_____

Stroke * Convulsions * Fainting Spells _____

_____

Epilepsy * Tumors or Growths * Arthritis * Rheumatism _____

_____

Have you ever had a major operation? _____ If yes, describe _____

_____

Have you ever had a serious injury to your head or neck? _____ If yes, describe _____

_____Are you on a special diet? _____ If yes, describe _____

Do you smoke or use tobacco? _____ Do you drink alcohol? _____ If yes, describe type and quantity/frequency _____

Have you consulted or been treated by a psychiatrist, psychologist or counselor for any reason?__

_____

Are there any other problems or conditions relating to your health of which you are aware?_____

_____

DENTAL HISTORY

Date of your last visit to a dentist _____ Reason _____

Do you have any of your X-rays or dental records? _____

What is the main reason you are seeking dental treatment at this time? _____

_____

In respect to any previous dental treatment, please circle and describe below if you have:

Ever Fainted * Had an Allergic Reaction * Experienced Excessive Bleeding

_____

Any other complications during or following dental treatment?_____ If yes, describe _____

_____

If you experience any of the following, please circle and describe below:

Bleeding Gums while Brushing or Eating * Food Catching Between Teeth * Shifting Teeth

New Spaces Between Teeth * Loose Teeth * Tooth Sensitivity to Hot, Cold, or Pressure

Teeth Grinding/Clenching * Jaw Pain or Clicking Around Your Ear * Sore Jaw Muscles

Sores, Lesions, or Growths in your Mouth * Currently Aching Teeth * Other _____

_____

_____

_____

All changes to your health status should be reported to the office at the earliest possible time.

_____To the best of my knowledge, the foregoing questions have been accurately answered. I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payors, and/or other licensed health practitioners.

Person completing this form: Print Name _____
Signature _____
Date _____
If other than the patient, indicate relationship _____

As a courtesy to our patients, we will promptly file your dental claims to your insurance company. However, the services provided for you are at a fee and regardless of the benefit allowances from your insurance carrier, you are responsible for all outstanding amounts on your account. All coinsurance amounts are due on the day of service.
By signing below you are agreeing to pay all outstanding charges in a timely manner.
signed:_____date:_____

Payment Policies

Payment is due at the time treatment is rendered.
Coinsurance for treatment of insured patients is due at the time service is rendered.
Should the patient not make payment in full at the time of treatment, a 1 ½ % billing charge will be added to the unpaid balance.
Should this office be required to employ an attorney or collection agency to enforce payment for treatment rendered, the patient agrees to pay the reasonable attorney/collection agency fees incurred for such enforcement.
There will be a $20.00 service charge on all returned checks.
Appointments must be cancelled 24 hours in advance. A $25.00 per half hour fee will be charged for broken appointments.

I understand that I am personally responsible for payment of services by Dry Creek Family Dentistry exceeding my insurance limits.

I agree to the payment policies stated above.

Signature _____ date _____