



Patient and Insurance Information

Name: _____ Preferred name: _____ DOB: _____

SS# _____ *Please circle one:* Minor Single Married *Please circle one:* Male Female

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

Please circle the number you prefer to be reached at

Phone #: _____ Work #: _____ Cell#: _____

Employer: _____

Email address: _____

Spouse or parent's name: _____ Phone #: _____

How did you hear about our office? _____

(friend/family, flier, drove by, other)

Responsible party if different than above

Name: _____ DOB: _____ SS#: _____

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

Employer: _____ Work #: _____

Insurance Information (If you have your card you do not need to fill this section out)

Name of Insured: _____ DOB: _____

Relationship to patient: _____

SS#: _____ Employer: _____ Phone #: _____

Insurance: _____ Group #: _____ ID #: _____

Insurance Phone #: _____

----- Do you have any additional insurance? If so please complete the following -----

Name of Insured: _____ DOB: _____ Relationship to patient: _____

SS#: _____ Employer: _____ Work

Phone: _____

Insurance: _____ Group #: _____ ID #: _____ Phone

#: _____

Health History Form

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. Medications and health conditions can sometimes affect your oral health and it is important for accurate diagnosis to have accurate information.

***We are a latex free office and will notify you if metal is necessary for any restorations

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____

If you are completing this form for another person, what is your relationship to that person? _____

Dental Information *Please mark yes or no*

Do your gums bleed when you brush or floss?..... Yes No

Date of last dental exam _____

Are your teeth sensitive to cold, hot, or pressure? Yes No

Do you have dry mouth?..... Yes No If dental treatment is needed would you like

Have you had any periodontal (gum) treatments?..... Yes No to have "laughing gas"..... Yes No

Have you ever had any problems associated with dental treatment?... Yes No There is a \$50 charge for every 30 minutes

Are you currently experiencing dental pain or discomfort?..... Yes No

How do you feel about your smile? _____

Medical Information *Please mark yes or no*

Are you under the care of a physician? Yes No

Name of Physician: _____ Phone: _____

Have you had any serious illness, operation, or been hospitalized in the past 5 years? Yes No

If yes, what was the illness or problem? _____

Are you currently taking any prescription or over the counter medications? Yes No

If yes, please list all, including vitamins, natural/herbal/diet supplements. (If you have a list we can make a copy for you)

Drug/Dosage	Prescribing Physician	Taken For
_____	_____	_____
_____	_____	_____
_____	_____	_____

Joint Replacement Have you had an orthopedic joint (hip, knee, elbow) replacement? Yes No Date _____

Has a physician recommended that you take antibiotics prior to your dental treatment? Yes No

Please mark yes or no to indicate if you have had or have not had any of the following diseases or problems.

Heart murmur..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid problems... <input type="checkbox"/> Yes <input type="checkbox"/> No
Mitral valve prolapse..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial heart valves..... <input type="checkbox"/> Yes <input type="checkbox"/> No	AIDS or HIV infection..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiovascular Disease.... <input type="checkbox"/> Yes <input type="checkbox"/> No	Autoimmune disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Angina (chest pain)..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Congestive heart failure.... <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney problems... <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart attack..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis..... <input type="checkbox"/> Yes <input type="checkbox"/> No
High blood pressure..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic pain..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Migraines..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Low blood pressure..... <input type="checkbox"/> Yes <input type="checkbox"/> No	STD..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Congenital heart defects... <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Pacemaker..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Gastrointestinal Disease... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Asthma..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Reflux/Heartburn..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Abnormal bleeding..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Mental health Disorders... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Neurological disorders..... <input type="checkbox"/> Yes <input type="checkbox"/> No		

Please explain any disorders or diseases along with any condition or problem not listed above: _____

Allergies: are you allergic to or have you have a reaction to: *Please mark yes or no*

To all **YES** responses, specify type of reaction.

Local anesthetics..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Metals..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Aspirin..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Latex (rubber)..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Penicillin or other antibiotics..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Iodine..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Barbiturates, sedatives, or sleeping pills.... <input type="checkbox"/> Yes <input type="checkbox"/> No	Hay fever/Seasonal..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Sulfa drugs..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Food..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Codeine or other narcotics..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Other..... <input type="checkbox"/> Yes <input type="checkbox"/> No

Reactions: _____

Women Only: *please mark yes or no*

Pregnant: Yes No Number of weeks: _____ Nursing: Yes No Taking birth control/hormones: Yes No

Signature of Patient/Legal Guardian: _____

INSURANCE AND FINANCIAL POLICY

At East Limestone Family Dental, we believe that you deserve the best care. For patients with dental insurance that means getting the most benefits for you. Here are some office policies and important information you should know.

- Your dental benefits are based upon a contract between your employer and insurance company. If you have any questions about your dental benefits contact your employer or insurance company directly. Most dental plans do not cover procedures completely.
- We currently accept many private insurance company plans. We estimate your portion based on the most up to date insurance information we have, but it is **ONLY AN ESTIMATE**. Our office can file a pre-treatment authorization with your insurance company at your request. The authorization is not a guarantee of coverage of payment.
- Our office will bill the insurance company provided to us. It is your responsibility to update insurance information with our office. If insurance does not pay within 90 days, East Limestone Family Dental reserves the right to request payment in full for services rendered from you and let you collect the insurance funds that are due to you. Our office cannot and will not be part of the legal contract between you and your insurance company.
- You are responsible for all charges incurred in our office. If action has to be taken regarding your account, a fee of \$50.00 will be added to your account. The undersigned agrees to pay all legal fees and court costs incurred by East Limestone Family Dental in the collection of this account.
- East Limestone Family Dental does require payment in full of your estimated portion at the time of service. We accept most major credit cards, cash and personal checks. A fee of \$50.00 will be charged per returned check.
- A specific amount of time is reserved especially for you in our office. Although, we understand situations arise that cannot be avoided. **If you must change or cancel your appointment, we require at least 24 hour notice. A cancellation fee of \$25.00 per hour per patient for a cleaning appointment, a cancellation fee of \$75.00 per hour per patient on the doctors schedule and \$150.00 cancellation fee for crown or bridge appointments on the doctors schedule will be charged without a 24 hour notice.**
- Our office confirms appointments by email, phone call and text message. **IF YOU DO NOT RESPOND WITHIN 24 HOURS OF YOUR APPOINTMENT TIME, YOUR APPOINTMENT IS UNCONFIRMED AND THE APPOINTMENT WILL BE CANCELED.**

I agree with all the above conditions

Print Name _____ Date _____

Patient/Guardian Signature _____

HEALTH INFORMATION PRIVACY PROTECTION ACT (HIPPA)

Effective April 14, 2003 federal law requires physicians & health care providers to obtain written consent before disclosing your personal information to any health care professional or any facility. To provide optimal care it may be necessary to disclose your information to other professionals or facilities. A copy of this letter is available at your request.

I agree with all the above conditions

Print Name _____ Date _____

Patient/Guardian Signature _____