EAST LIMESTONE
FAMILY DENTAL

Patient and Insurance Information

Name: ______________________ Preferred name: ____________ DOB:__________

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

Address:___________________ City:__________ State:______ Zip:_________

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)

Dental Insurance Information

Name of Insured:________________ DOB:_________ Relationship to patient:__________

SS#: ______________ Employer:_________________ Phone #:________________

Insurance: ______________ Group #:_____________ ID #:______________

Responsible party

Name:_______________ DOB: _____________ SS#: _________________

Address:________________ City:_________ State:________ Zip:_________

Employer: ________________ Work #:______________

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.

PLEASE COMPLETE THE FOLLOWING 2 PAGES --------------------->

HEALTH AND DENTAL HISTORY

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
Have you had any periodontal (gum) treatments?................................ ___Yes ___ No
Have you ever had any problems associated with dental treatment?... ___Yes ___ No
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.................___Yes ___ No
Mitral valve prolapse.........___Yes ___ No
Artificial heart valves.........___Yes ___ No
Rheumatic Fever.............___Yes ___ No
Cardiovascular Disease....___Yes ___ No
Angina (chest pain)...........___Yes ___ No
Congestive heart failure.....___Yes ___ No
Heart attack.....................___Yes ___ No
High blood pressure..........___Yes ___ No
Low blood pressure...........___Yes ___ No
Congenital heart defects...___Yes ___ No
Pacemaker.......................___Yes ___ No
Asthma.............................___Yes ___ No
Abnormal bleeding...........___Yes ___ No
Neurological disorders......___Yes ___ No

Anemia.............................___Yes ___ No
Hemophilia........................___Yes ___ No
AIDS or HIV infection.......___Yes ___ No
Arthritis............................___Yes ___ No
Autoimmune disease.......___Yes ___ No
Emphysema......................___Yes ___ No
Tuberculosis.....................___Yes ___ No
Cancer..............................___Yes ___ No
Chronic pain......................___Yes ___ No
STD...................................___Yes ___ No
Diabetes............................___Yes ___ No
Gastrointestinal Disease...___Yes ___ No
Reflux/Heartburn...............___Yes ___ No
Mental health Disorders....___Yes ___ No

Thyroid problems.....___Yes ___ No
Stroke....................___Yes ___ No
Hepatitis.................___Yes ___ No
Liver disease..........___Yes ___ No
Epilepsy.................___Yes ___ No
Fainting..................___Yes ___ No
Kidney problems.....___Yes ___ No
Osteoporosis...........___Yes ___ No
Migraines...............___Yes ___ No

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

Allergies: *Please mark yes or no.* **To all YES responses, specify the type of reaction.**

Local anesthetics......................................___Yes___No
Aspirin...___Yes___No
Penicillin or other antibiotics.....................___Yes___No
Barbiturates, sedatives, or sleeping pills...___Yes___No
Sulfa drugs..___Yes___No
Codeine or other narcotics.........................___Yes___No

Metals...............................___Yes___No
Latex (rubber).....................___Yes___No
Iodine...............................___Yes___No
Hay fever/Seasonal...........___Yes___No
Food.................................___Yes___No
Other................................___Yes___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, which will include a **3.9% fee** for service, 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 $75.00 per hour per patient for a cleaning appointment, a cancellation fee of $100.00 per hour per patient on the doctors schedule and $200.00 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 understand and agree with all the above information and 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 understand and agree with all the above information and conditions

Print Name ______________________________ Date ______________

Patient/Guardian Signature ______________________________