



Patient and Insurance Information

Name: _____ Preferred name: _____ DOB: _____

SS# _____ Please circle: Minor Single Married Divorced Widowed Separated

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

Please circle the number you prefer to be reached at

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

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: _____ Work Phone: _____

Insurance: _____ Group #: _____ ID #: _____ 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
Low/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
Congenital heart defects... <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes..... <input type="checkbox"/> Yes <input type="checkbox"/> No	STD..... <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
Abnormal bleeding..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Reflux/Heartburn..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Neurological disorders..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Mental health 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..... 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 Are you: *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. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits, but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

- Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.
- We currently accept many private care insurance plans. This means that we work with literally hundreds of companies. Although we can maintain computerized histories of payment given by a company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. If you would like you know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you the exact out-of-pocket figures you may require.
- We will bill your insurance as a courtesy. If insurance does not pay within 90 days, East Limestone Family Dental reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between you and your insurance company. Our office is not, and connate be a part of that legal contract. In the event collection action has to be taken regarding this account, the undersigned agrees to pay legal fees and court cost incurred by East Limestone Family Dental in collecting this account. Ultimately, you are responsible for all charges incurred in our office.
- East Limestone Family Dental does require payment in full for your portion at the time of service. We accept most major credit cards, cash and personal checks. If you are in need of an extended finance option we will gladly open a 90 day interest free in house account with approved credit. We also work with CareCredit, a commercial creditor, who offers an interest bearing revolving line of credit designed to meet your treatment plan needs and is also based upon approval. Returned checks will be charged a fee of \$30 per check.
- A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hour notice to avoid a \$25 per hour per patient cancellation fee.

I agree with the above conditions:

Print Name: _____ Date: _____

Patient/Guardian Signature: _____

HEALTH INFORMATION PRIVACY PROTECTION ACT (HIPPA)

Effective April 14,2003 new federal law requires physicians and health care providers to obtain written consent before disclosing your personal health information to other health care professionals or facilities. Please know that complete confidentiality is a priority of the highest magnitude in our office. However, in the course of providing optimal care for you it may be necessary to disclose diagnoses or lab results to other physicians or facilities directly related to your care. A copy of this policy is available at your request.

I agree with the above conditions:

Print Name: _____ Date: _____

Patient/Guardian Signature: _____