East Limestone Family Dental
DR. SCOTT FITTS, DMD

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

#:_____

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: _____

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…….___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: 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: *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:_____