Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Date_____

PATIENT INFORMATION

Name: _____
Last First M.I.

Address _____City _____State _____Zip _____

Home Phone: _____Cell Phone: _____

SS#:_____Birthdate: _____

E-Mail: _____Preferred Name:_____

Check Appropriate Box:

☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient or Parent/Guardian's Employer _____

Business Address_____City_____Work Phone _____Ext._____

Spouse or Parent/Guardian's Name_____Employer _____Fax_____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____Phone _____

RESPONSIBLE PARTY

Name of person responsible for this account _____Relationship to Patient _____

Address _____Home Phone _____

E-Mail _____Cell Phone _____

Driver's License # _____Birthdate _____

Employer _____Work Phone _____SS# _____

Is this person currently a patient in our office? Yes ☐ No ☐

DENTAL HISTORY

Name of previous dentist_____Date of last cleaning _____

Previous dentist's location _____Date of last X-rays _____

	Yes	No	
1. Are you satisfied with your smile?	☐	☐	If no, please explain why
2. Do your gums bleed while brushing or flossing?	☐	☐	
3. Are your teeth sensitive to hot or cold temperatures or sweets?	☐	☐	
4. Do you have any sores or lumps in or near your mouth?	☐	☐	
5. Do you feel pain to any of your teeth?	☐	☐	
6. Have you had any head, neck or jaw injuries?	☐	☐	
7. Circle any of the following you may have: Clicking Pain (joint, ear, side of face) Difficulty in opening or closing Difficult in chewing			
8. Do you have frequent headaches?	☐	☐	
9. Do you clench or grind your teeth?	☐	☐	
10. Do you bite your lips or cheeks frequently?	☐	☐	
11. Have you ever had any difficult extractions in the past or any prolonged bleeding following extractions?	☐	☐	
12. Have you had any orthodontic treatment?	☐	☐	
13. Do you wear dentures or partials?	☐	☐	If yes, date of placement _____
14. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐	

MEDICAL HISTORY FORM

Please answer all questions thoroughly. This information is for our records only and will be kept strictly confidential. FOR THE FOLLOWING QUESTIONS, PLEASE CHECK ALL ANSWERS THAT APPLY. IF NONE APPLY, PLEASE CHECK NONE.

Do you have, or have you ever had any of the following:

☐ Mitral Valve Prolapse ☐ Rheumatic Fever ☐ Vascular Shunt ☐ High Blood Pressure ☐ Coronary Occlusion
☐ Heart Murmur ☐ Stroke ☐ Heart Attack ☐ Chest Pain ☐ Artificial Heart Valves
☐ Arteriosclerosis ☐ Pacemaker ☐ Heart Surgery ☐ Congestive Heart Failure ☐ Heart Defect
☐ None

☐ Aids/HIV ☐ Hepatitis ☐ Tuberculosis ☐ None

Are you allergic to any of the following:

☐ Penicillin ☐ Sulfa ☐ Erythromycin ☐ Local Anesthetics ☐ None
☐ Codeine ☐ Nickel/Other Metals ☐ Latex ☐ Other Medicine

Do you have, or have you had any problems with the following:

☐ Sinus Trouble ☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Other Respiratory Problems
☐ Diabetes ☐ Thyroid disorder ☐ Liver Problems ☐ Kidney or Adrenal Problems ☐ Jaundice
☐ Digestive Problems ☐ Colitis ☐ Stomach Ulcer ☐ Hiatal Hernia ☐ Neurological Problems
☐ Fainting ☐ Seizures ☐ Epilepsy ☐ Mental Health Problems ☐ Depression
☐ Abnormal Bleeding ☐ Clotting Problems ☐ Phlebitis ☐ Anemia ☐ Transfusions
☐ Cancer ☐ Tumor(s) ☐ Cyst ☐ Biopsy ☐ None
☐ Arthritis ☐ Artificial Joints ☐ Muscle or Bone Disease

Do you: ☐ Smoke ☐ Drink Alcohol ☐ Use Illegal Drugs ☐ Use chewing tobacco/snuff

Have you ever been: ☐ Hospitalized ☐ Operated On ☐ Treated for any condition not on this form ☐ None

If yes, please explain: _____

Are you currently taking any of the following: ☐ Aspirin ☐ Coumadin ☐ Blood Pressure Medications ☐ Pain Medication ☐ None

List all medications you are currently taking: _____

_____

The name of my physician is: _____ City, State _____

Women are you: ☐ Pregnant ☐ Taking Birth Control Pills ☐ Nursing ☐ None

I understand that this medical history is a legal document and that I have answered all of the above questions to the best of my ability and knowledge and I will not hold my dentist or any other staff members responsible for any errors or omissions I may have made in the completion of this form.

Signature of Patient or Legal Guardian x _____

Please list any changes in your health history since your last dental visit. _____
Please list any new medications you are currently taking since your last dental visit. _____
Patient's Signature _____ Date _____

Please list any changes in your health history since your last dental visit. _____
Please list any new medications you are currently taking since your last dental visit. _____
Patient's Signature _____ Date _____

Please list any changes in your health history since your last dental visit. _____
Please list any new medications you are currently taking since your last dental visit. _____
Patient's Signature _____ Date _____

DENTAL INSURANCE

Welcome to our practice! As a courtesy to our patients, we will gladly file your primary dental insurance once your coverage has been confirmed.

At the time of service, you will be asked for an estimated co-payment and any deductible which may apply. Each insurance company agrees to pay different amounts for services rendered. Although we may know what insurance companies say they will cover and what they have covered in the past, we can never be assured of what they will pay on any given claim. Therefore, when our office staff asks for payment at the time of service, the amount we will request is only an estimate of what you will actually owe.

If the insurance payment is more than what was estimated, you will be left with a credit and will have the option of either applying this credit to other treatment or obtaining a prompt refund. If the insurance payment is less than estimated, you will be left with a balance due and payable.

In either case, please understand that once treatment is performed, the person responsible for the account is ultimately responsible for any charges made to the account. If for any reason the insurance company has not paid a claim in 60 days, the full balance will become due and payable.

We do not file secondary insurance, but will be happy to give you filing instructions.

Please do not hesitate to ask if you have any questions.

PRIMARY INSURANCE INFORMATION

Name of insured _____Relationship to patient _____

Birthdate: _____SS#_____

Insured Address (if different from patient's) _____

Name of Employer _____Work Phone _____

Employer Address _____City _____State____Zip_____

Insurance Company _____Group # _____Ins. Phone #_____

Ins. Co. Address _____City _____State ____Zip _____

_____(initial) Your dental insurance is your financial responsibility. We will try to help calculate your dental benefit in dollars, but we must stress the fact that you, the patient, are responsible for the TOTAL cost of your dental treatment.

AUTHORIZATION AND RELEASE:

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination renderd to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient (or parent/guardian if minor)

BOURBON FAMILY DENTISTRY

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

Patients Name: _____ Date of Birth: _____

I request that the following be allowed for the disclosure of my PHI (Protected Health Information). PHI will include your name, diagnosis(es), test results, dates of services.

- You may disclose information to my family members and or non-family members. Please list name phone number and relationship.

NAME	PHONE NUMBER	RELATIONSHIP

- For minor children, please list those who are able to bring the patient to the appointment and act on your behalf, should you not be able to attend.

NAME	PHONE NUMBER	RELATIONSHIP

- You may leave PHI on my answering machine/voicemail.
    - Phone/Cell number: _____
    - Other: _____

Printed Name: _____ Date: _____

Patient/Guardian's Signature: _____

BOURBON FAMILY DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

You may refuse to sign this acknowledgement

I, _____, have received a copy of the Notice of Privacy Practice statement.

Patients name:

_____

Patient/Guardian's Signature:

_____

Date: _____