Welcome

Family Dentistry

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us--We will be happy to help.

Today's Date________________________

Patient Information (Confidential):

Name______________________________________ Birthdate____________ Social Security #_____________

Address____________________________________ City______________________ State_______Zip________

Home Phone_____________________ Work Phone_________________ Other_________________________

Email Address____

Check Appropriate Box: ☐ Minor ☐ Single ☐Married ☐Other

Patient's or Parents Employer____

Business Address____________________________ City________________________ State______Zip_______

Spouse or Parent's Name______________________________ Employer_________________________________

If Patient is a Student, Name of School/ College________________Full Time Student____________________

Whom May We Thank for Referring You?____

Person to Contact in Case of Emergency__________________________________Phone Number___________

Responsible Party:

Name of Person Responsible for this Account_____________________________Relationship to patient________________

Address____Home Phone________________

Social Security #______________________________ Birthdate______________________

Insurance Information: Please give your card to the front personnel for photocopy.

ID#__________________Medicaid #__________________ BCBS Chips #___________________

We file dental insurance as a courtesy to you. We will file Primary insurance only, but we will assist you in filing your Secondary insurance. At each visit, we will estimate your deductible and percentage to be paid that day. Please remember that insurance coverage is between the company and the individual. We will do our best to estimate what your insurance will pay, but you are ultimately responsible for your account. If your insurance has not paid in 60 days then you are to pay the balance. We will be sending monthly statements to allow you to keep up with the progress of your insurance.

X____ Date________________________

Patient Medical History

Physician________________________________ Office Phone________________________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s) Including non-prescription medicine	☐	☐
If yes, what medication are you taking ______________________________		
4. Do you use tobacco?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Are you wearing contact lenses?	☐	☐

7. Are you allergic to or have you had any reactions to the following?	Yes	No
Local Anesthetics (eg. Novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Codeine	☐	☐
Other	☐	☐
______________________________________		
8. ***Women Only***:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

9. Do you have or have you had any of the following? ***Circle the ones that apply.***

AIDS or HIV infection
Anemia
Asthma
Cancer
Diabetes
Type I
Type II
Medications if any____________________
____
Emphysema
Epilepsy/ Convulsions
Fainting/Seizures
Hay Fever/Allergies
Heart Disease
Heart Murmur
Heart Attack
Cardiac Pacemaker

Hepatitis/Jaundice
High Blood Pressure
Joint Replacement or Implant
Kidney Disease
Leukemia
Liver Disease
Low Blood Pressure
Radiation Therapy
Respiratory Problems
Rheumatic Fever
Sexually Transmitted Disease
Thyroid Problem
Tuberculosis
Other (please specify)____________________________________
____
PRE-MEDICATION

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such Dental care to third party payers 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 payments of all services rendered on my behalf or my dependents. I authorize the dentist to use my dental photos of my procedures for educational purposes if needed.

X____ Date___________________

W. Mark Donald, D.M.D. Family Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowlegdement

I____________________________have received a copy of this Office's Notice of Privacy Practices

____
Please Print Name of Patient

____
Signature of Patient or Guardian

____
Date

We attempted to obtain written acknowledge of receipt of our Notice of Privacy Practices, but Acknowledgement could not be obtained because:

_____ Individual refused to sign
_____ Communications barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (Please Specify)

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