Medical History Update

Date:_____ **Name:**_____**DOB:**_____
Address:_____
Ph: (H)_____**(C)**_____**Email:**_____
Emergency contact:_____**Relationship:**_____**Ph:**_____
Please circle any conditions that apply:

Arthritis
Artificial Joint/Replacement
******Require premed*_____
******Year*_____
Asthma
******Do you carry an inhaler*____
Autism/ Asperger's
Back and/or Neck Fusion
Blood Disease
Cancer
*Type:*_____
year:_____
Chemotherapy *year*:_____
Chronic dry mouth
C.O.P.D (*Bronchodilator/Steroid)*
Diabetes I or II
Emphysema
Epilepsy or Seizures
Excessive Bleeding
Fainting or Dizziness
Fibromyalgia
Glaucoma
Heart Disease *year:*_____
Heart Attack *year*:_____
***** *Do you carry nitroglycerin*___
Heart Murmur
Hepatitis A
Hepatitis B
Hepatitis C
High Blood Pressure
High Cholesterol
HIV/AIDS
Kidney Disease
Liver Disease
Mental Disorder
Multiple Sclerosis
Respiratory Problems
Rheumatism
Sexually Transmitted Disease
Sinus Problems
Stroke
Thyroid Disease
Tuberculosis (TB)
Other Conditions:
_____
_____

***How would you rate your overall health?**
Excellent / Good / Fair / Poor
Height_____ Weight_____
***Do you have any allergies to any medications or anesthetics?** *Please circle*
PCN / Sulfa / Aspirin / Epinephrine / Latex /Amoxicillin /Clindamycin / Sulfites / Codeine / Other:_____
Type of reaction:_____
Does your heart ever beat rapidly after a dental injection?___

***Please list and date any hospitalizations, surgeries or blood transfusion**: (in the past 2 years)
_____
_____

***Do you need to take a premedication before a dental appointment**? Yes No
For what: _____Medication_____

Do you use tobacco products? Yes No
*How much and how often*_____
Do you consume alcohol on a regular basis? Yes No
Do you use recreational drugs? Yes No
Number of Carbonated beverages per day? _____
Women:
Are you currently Pregnant?___ Weeks?_____
Are you nursing?_____
Going through menopause?___ Post-menopausal?_____

Please list <u>ALL</u> of the medications you take: **(Including prescription, over-the-counter, vitamins or supplements)**

Name of Medication	Dosage	Frequency	Reason

Physician_____ Phone _____
Specialist_____ Phone _____
Pharmacy_____ Phone_____
To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any change in my health or medications, I will inform the Doctor at my next appointment without fail.

X_____ _____
Patient Signature *Date*

Acknowledgment of Receipt of Notice of Privacy Practices: Healthy Smiles Dental, LLC

____ I have received this office's Notice of Privacy Practices, which explains how my dental information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Patient Privacy Questionnaire:

1. **Please list the family members or other persons, if any, whom we may inform about your general medical/dental condition and diagnosis (including treatment, payment and health care operations).**

_____ _____

_____ _____

(Name and Relationship)

2. **Can confidential messages (e.g., appointment reminders) be left on your telephone answering machine or voicemail? ☐ Yes ☐ No**

_____ _____ _____

Patient/Guardian Signature **Print Patient Name/Guardian** **Date**

Patient Treatment and Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health.

Payment Options Include:

- Cash, Check, American Express, Discover, Mastercard, Visa (*Additional fee $35.00 will be applied for returned checks*.)
- CareCredit – interest free up to 6 months over $200 (cannot be used with any other discount or offer)

Courtesy Adjustments will be offered as follows:

- 5% discount for cash or check payments ***at the time of service*** (apply to non-insured patients only)
- 10% senior citizen discount for cash or check payments – 62/older (apply to non-insured patients only)

*****Courtesy adjustments will not be automatically applied and cannot be made retroactive*****

*****One adjustment type per visit. Courtesy adjustments will not be combined with Care credit*****

Consent for treatment: I understand that as the treatment proceeds there may be need to change the treatment plan. If this occurs I expect to be informed before any change is instituted.

I further understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions during or following any treatment, I agree to report them to the office as soon as possible. I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.

Do you have insurance?

• As a courtesy to you, we will help you process all of your dental insurance claims. ***Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated***. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Please contact your insurance company for a detail of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to several reasons, specifically related to your plan.

- All charges you incur are your responsibility, regardless of your insurance coverage. ***We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company.*** Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract.

- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. I authorize the release of any information concerning my (or my child's) health care advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

- We ask that you pay the deductible, co-payment and co-insurance, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, Discover, American Express and CareCredit at the time we provide the service to you.

- Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Minors accompanied by the parent or legal guardian: The parent or legal guardian accompanying a minor, who has consented to treatment are responsible for full payment at time of service.

Unaccompanied Minors: The parent or legal guardian is responsible for full payment at time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or nonemergency treatment may be denied.

Missed Appointment (s) and Cancellations: Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best services to our patients***, we require at least a 24-hour notice for cancellations or for re-scheduling your appointments.*** We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment***. We reserve the right to charge a $50 fee for multiple missed, short notice or cancelled appointments***. Multiple failed appointments may result in being dismissed from the dental practice.

Communications with you: By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us. Our office may call by telephone regarding your account. You agree that we may place such calls using an automatic dialing/announcing device. You agree that we may make such calls to a mobile telephone or other similar device.

Consent: I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Patient /Parent name printed_____

Patient /Parent signature_____ **Date**_____