Bonifay Office
110 East North Avenue
Bonifay, Florida 32425
850-547-9290

FAMILY DENTISTRY

Chipley Office
1410 A Brickyard Rd.
Chipley, FL 32428
850-415-1411

PATIENT INFORMATION

DATE _____

NAME _____ ☐MARRIED ☐SINGLE ☐MINOR ☐MALE ☐FEMALE

ADDRESS _____ CITY _____ STATE _____ ZIP _____

BIRTHDATE _____ SS# _____ HOME PHONE _____

EMAIL ADDRESS _____ CELL PHONE _____

PLACE OF EMPLOYMENT _____ TELEPHONE _____

PERSON RESPONSIBLE FOR ACCOUNT- PLEASE CHECK ONE ☐PATIENT ☐GUARDIAN ☐SPOUSE ☐FATHER ☐MOTHER

EMERGENCY CONTACT NAME _____ **TELEPHONE** _____

MEDICAL HISTORY

Are you under a physician's care now? Why? _____ Who? _____ Phone? _____ ☐Yes ☐No

Have you ever been hospitalized or had a major operation? Discuss _____ ☐Yes ☐No

Have you ever had a serious injury to your head or neck? Discuss _____ ☐Yes ☐No

Are you taking any medications, pills or drugs? What? _____ ☐Yes ☐No

Are you allergic to any medications or substances? _____ **Please check box below:** ☐Yes ☐No

☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex Rubber ☐Other _____

Women (Please check) ☐Pregnant/trying to get pregnant ☐Nursing ☐Taking oral contraceptives

Is there anything about your smile you would like to change? ☐Yes ☐No

Are you interested in whitening your teeth? ☐Yes ☐No

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	☐	☐	Blood Disease	☐	☐	Breathing Problem	☐	☐	Liver Disease	☐	☐	Drug/Alcoholism Addiction	☐	☐
Irregular Heart Beat	☐	☐	Bruises Easily	☐	☐	Asthma	☐	☐	Hepatitis	☐	☐	Cold Sores	☐	☐
Angina/Chest Pain	☐	☐	Anemia	☐	☐	Emphysema	☐	☐	KidneyProblems	☐	☐	Stroke	☐	☐
Heart Attack/Failure	☐	☐	Excessive Bleeding	☐	☐	Turberculosis	☐	☐	Renal Dialysis	☐	☐	Epilepsy/Seizures	☐	☐
Congenital Heart Disorders	☐	☐	Sickle Cell Disease	☐	☐	Cancer	☐	☐	Thyroid Disease	☐	☐	Fainting or Dizziness	☐	☐
Artificial Heart Valve	☐	☐	Hemophilia	☐	☐	Radiation Treatments	☐	☐	Arthritis/Gout	☐	☐	Glaucoma	☐	☐
Mitral Valve Prolapse	☐	☐	Leukemia	☐	☐	Chemotherapy	☐	☐	Pain in Jaw/Joints	☐	☐	Tumors or Growths	☐	☐
Heart Pace Maker*	☐	☐	Recent Blood Transfusion	☐	☐	Stomach/Intestinal Disease	☐	☐	Cortisone Medicine	☐	☐	Nervousness	☐	☐
High Blood Pressure	☐	☐	Swelling of Limbs	☐	☐	Diabetes/Hypoglycemia	☐	☐	Artificial Joint*	☐	☐	Psychiatric Care	☐	☐
Low Blood Pressure	☐	☐	Lung Disease	☐	☐				HIV Positive	☐	☐	Allergies (Medicines)	☐	☐
												Need Premedication?	☐	☐

Have you ever had any other serious illness not checked above? Discuss _____ ☐Yes ☐No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change. I shall inform the dentist and staff at the next appointment without fail.

X _____ _____

Patient Signature (Parent or Guardian) DATE

Reviewed by Doctor _____ **Date** _____ **BP** _____

History Review and Significant Findings _____

Our mission at Family Dentistry is to serve all of your oral healthcare needs, but our mission in life is to serve our risen Lord and Savior, Jesus Christ. We've asked you a lot of questions on this form but the most important question you'll ever answer is:

"If you were to die today, do you know where you would spend eternity"? We would love the opportunity to discuss this with you.

USBPi REORDER #11939 (REV. 03/16)

AUTHORIZATION

The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals. I understand that I am responsible for all costs of dental treatments. I hereby authorize the dental office to administer such medications and perform such diagnostics, photographic and therapeutic procedures as may be necessary for proper dental care. I hereby authorize insurance payments be made directly to the dental office.

X _____

Patient or Responsible Party Signature

FAMILY DENTISTRY OF NORTHWEST FLORIDA

Dental Insurance Information:

Patient Name_____ **Date of Birth**_____

Primary Insurance
Policy Holder
Name:_____

Secondary Insurance
Policy Holder
Name:_____

Insurance Co:_____

Group Number_____

SS#_____

Insured date of Birth:_____

Employer:_____

Insurance Co:_____

Group Number_____

SS#_____

Insured date of Birth:_____

Employer:_____

Address of Insured (if different from patient)_____

RELEASE OF INFORMATION – HIPAA (Privacy Practice Act)

It is the policy of this office to maintain strict confidentiality concerning the care and/or treatment received here. However, there are times and circumstances in which you may wish us to speak with someone else about these matters. Do we have permission to:

Send appointment reminders via text message? ___Yes ___No
(If yes, please indicate mobile number on medical history sheet)
Leave a message on your voicemail at home/mobile? ____Yes ____No
Call you at work? ____Yes ____No
Leave a message at your place of employment? ____Yes ____No
Discuss your medical/dental condition with any family member or friend?
(If yes, please list below) ____Yes ____No

Name:_____ Relationship_____Phone #_____

My signature below authorizes the Doctor to release my medical/dental information to the persons listed on this page, my primary care or referring Doctor, to consultants if needed, to my insurance company as necessary to process my insurance claims (if any) and as needed for prescription drugs.

In signing below, I acknowledge my understanding of and acceptance of the policies of this office as stated above and agree to abide by the terms listed above. I authorize payment of dental benefits to the Dentist when an assigned claim is filed.

Signature:_____Date_____

FAMILY DENTISTRY OF NORTHWEST FLORIDA
FINANCIAL POLICY FOR PATIENT ACCOUNTS

Full Payment is due at the time of service. We accept cash, checks and credit cards. Patients who provide false or inaccurate information at the time of their visit, such as false address or false insurance information, will immediately have their account turned over to a collections bureau that specializes in fraudulent case collections. **A $25.00 service fee will be charged on all returned checks.**

Insurance: You are required to pay all patient responsible portions such as deductibles and co-payments at the time of service. **You should be aware that your insurance policy is a contract between you and your insurance company.** It is your responsibility to ascertain that the dentist you are seeing is participating in your insurance plan. **As a courtesy we will file your insurance claim, but you will be 100% responsible for all charges.**

Usual and Customary Rates: We charge what is usual and customary for our area. We are **not** responsible for any insurance company's arbitrary determination of what are usual and customary rates. It is your responsibility to ascertain that the dentist you are seeing is participating in your insurance plan. You may incur charges for services not covered by your plan. You will be responsible for these charges regardless of your insurance coverage. **Patients are responsible for balances left over from partial payment by insurance companies.**

Past Due Accounts: Patient accounts that are over 60-90 days past due may be transferred to a collection agency at the discretion of this office with or without notice to the patient or responsible party. Patient will be responsible for all collection agency fees (33.33% of account balance). Our office and/or the collections agency will use all given contact numbers, including wireless telephone numbers in order to contact you in reference to the account, which could result in charges to you. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable. Your monthly statement serves as your reminder of your responsibility with past due accounts.

By signing below, I have read and fully understand the above statements.

_____

Patient or Responsible Party Signature Date

_____

Patient or Responsible Party Name (Please Print) Telephone Number

_____

Street City State

_____

SS#(person responsible for account) Date of Birth (person responsible for account)

Broken Appointments: It is the policy of Family Dentistry of Northwest Florida, Chipley & Bonifay location, that anyone with two broken appointments can be dismissed from the practice. The following are considered broken appointments: failure to show for appointments with hygiene or doctors without notice and late cancellations less than 24 hours in advance. Broken appointments may incur a charge of $1 a minute of allotted appointment time ($30 for a 30 minute appointment, $60 for a 1 hour appointment, etc.). Also, patients showing more than 15 minutes late for appointments may not be seen that day, and will therefore need to reschedule to a later date and may be charged a broken appointment fee.

Signature:_____DATE_____