SPRING-FORD familydental

Patient Name _____ Date _____

Male _____ Female _____ Single _____ Child _____ Married _____ Divorced _____

Address _____

Phone Home _____ Work _____ Cell_____

Social Security Number _____ Birth Date _____

E-mail address _____

Health Information

Date of last dental visit _____ Last films _____

Reason for today's visit _____

Please list any medications you currently take _____

Have you ever had any of the following? Please circle all that apply.

Excessive Bleeding	Y / N	Liver Disease/Hepatitis	Y / N	Stroke	Y / N
Respiratory Problems	Y / N	Allergies	Y / N	Fainting	Y / N
Anxiety/Depression	Y / N	Mitral Valve	Y / N	T.B.	Y / N
Glaucoma	Y / N	Nervous Disorder	Y / N	High Cholesterol	Y / N
Anemia	Y / N	Growths	Y / N	Pacemaker	Y / N
Ulcers	Y / N	Arthritis	Y / N	Blood Thinner	Y / N
Thyroid Disease	Y / N	Heart Disease	Y / N	Artificial Joint	Y / N
Head Injury	Y / N	Cancer	Y / N	Radiation Treatment	Y / N
Tumors	Y / N	Epilepsy	Y / N	High Blood Pressure	Y / N
Asthma	Y / N	Rheumatic Fever	Y / N	Kidney Disease	Y / N
Sinus Problems	Y / N	Diabetes	Y / N	Heart Murmur	Y / N
Stomach Problems	Y / N	ImmunoCompromised Condition	Y / N		
Currently Pregnant	Y / N	Due Date _____			

ALLERGIES TO ANY MEDICATIONS? _____

Have you ever had complications from dental treatment? If yes, please explain.

_____

Have you been admitted to a hospital or needed emergency care during the past two years?

If yes, please explain. _____

Primary Physician Name _____ Phone Number _____

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Dental History

How often do you brush your teeth? _____ How often do you floss? _____

Do your gums bleed? Y / N
Do you have difficulty chewing? Y / N
Do you have clicking in your jaw or TMJ discomfort? Y / N

Are you pleased with the color of your teeth? Y / N
Are you pleased with the position of your teeth? Y / N
Are you pleased with the shape of your teeth? Y / N

Is there anything about your mouth you would like to be improved? If so, please explain:

_____

_____

Responsible Party Information

The following is for the patient's spouse _____ or the person responsible for payment _____

Name _____ M / F Phone Number _____

Address _____

Social Security Number _____

Employer Name _____ Occupation _____

Employer Address _____

Employer Phone Number _____

Whom may we thank for referring you to our dental practice? _____

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Dental Insurance Information

Name of Insured Person _____

Birth Date _____ Social Security Number _____

Insurance Company Name _____ Phone Number _____

ID Number _____ Group Number _____

Address _____

Consent for Services

I understand that I am responsible for all fees at the time of services. I understand that my insurance is a contract between myself and the company, and that I am responsible for all debt. Dr. Thomas will bill them directly, as a courtesy to me. All emergency treatment must be paid at time of services, no credit will be extended. I am aware that a finance fee of 18% will be charged to my account for all balances over 90 days. I accept any pre-treatment estimates for a period of no more than 60 days. I grant my permission to Dr. Thomas to release my information to my insurance company. I am responsible for any and all collection fees, if applicable. I have read the above conditions and agree to this contract.

Signature _____ Date _____

HIPAA Acknowledgement of Practice Privacy Notice

Under the HIPAA Privacy Rule, Spring-Ford Family Dental is required to disseminate its Notice of Privacy Practices to all patients upon the first delivery of service after April 14, 2003.I acknowledge that I have received a Notice of Privacy Practices from Spring-Ford Family Dental.

Signature _____ Date _____

Relationship to patient if Legal Representative _____