DENTISTRY AT VICKERY CREEK

Considerate, Gentle Care

HEALTH HISTORY:

Last Name _____ First Name _____ MI ___ Preferred Name _____
Address _____ City _____ State _____ Zip Code _____ Date _____
Email _____ HM Phone _____ Cell Phone _____
WK Phone _____ Birthdate _____ Age _____ Sex Male or Female __ Martial Status ___
Patient SS# _____ Occupation _____ Employer Name _____
Employer Address _____ Employer Phone _____
Spouse Name _____ Birthdate _____ Occupation _____
Spouse's Employer _____

INSURANCE INFORMATION:

Whom may we THANK for referring you? _____
Who is responsible for this account? _____ Relationship to patient _____
PRIMARY Insurance _____ Phone # _____ Is pt. covered by additional ins? Y/N __
Insurance Address _____ Group Number _____
Subscriber's Last Name _____ First Name _____MI ___ Subscriber's Birthdate _____
Subscriber's SS# or ID# _____ Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other
SECONDARY Insurance _____ Phone # _____ Is pt. covered by additional ins? Y/N __
Insurance Address _____ Group Number _____
Subscriber's Last Name _____ First Name _____ MI ___Subscriber's Birthdate _____
Subscriber's SS# or ID# _____ Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other

ASSIGMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____ Relationship _____ Date _____

DENTAL HISTORY:

Reason for today's visit _____
Former Dentist _____ Address _____
Phone # _____ Date of last dental visit _____ Date of last dental X-RAYS _____
Please CHECK to indicate if you have had any of the following and when:

Bad breath	☐	Do you have Implants, dentures, partials	☐	Nervous or bad experience	☐
Bad experience in dental office	☐	Food or floss catch between teeth	☐	Orthodontic treatment	☐
Bleeding Gums	☐	Foreign objects	☐	Pain around ear or neck pains	☐
Blisters on lips or mouth	☐	Fingernail biting	☐	Periodontal history	☐
Burning sensation on tongue	☐	Grinding teeth – consciously or sleep	☐	Problems getting numb	☐
Chew on one side of mouth	☐	How often do you brush? _____	☐	Sensitivity to cold or hot	☐
Chewing tobacco	☐	How often do you floss? _____	☐	Sensitivity to Sweets or pressure	☐
Dry mouth	☐	Jaw pain or tiredness	☐	Sensitivity when Biting	☐
Difficult with previous dental work	☐	Lip or cheek biting	☐	Smoking – Cigarettes, pipe, cigars	☐
Do you have click & pop in jaw joint	☐	Loose teeth or broken fillings	☐	Sores or growths in mouth	☐
Do you like your smile	☐	Mouth breathing	☐		

If you could change anything about your mouth, teeth, or smile, what would it be? _____

MEDICAL HISTORY:

Although dental personnel primarily treat the areas in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Physician's Name _____ Phone Number _____ Date of last visit _____

Please CHECK to indicate if you have had any of the following and when:

AIDS ☐	Cortisone Medicine ☐	Herpes ☐	Recent Weight Loss ☐
Alzheimer's Disease ☐	Diabetes I or II ☐	High Blood Pressure ☐	Renal Dialysis ☐
Anaphylaxis ☐	Drug Addiction ☐	High Cholesterol ☐	Rheumatic Fever ☐
Anemia ☐	Easily Winded ☐	HIV Positive ☐	Rheumatism ☐
Angina ☐	Emphysema ☐	Hives or Rash ☐	Scarlet Fever ☐
Arthritis / Gout ☐	Epilepsy or Seizures ☐	Hypoglycemia ☐	Shingles ☐
Artificial Heart Valve ☐	Excessive Bleeding ☐	Irregular Heartbeat ☐	Shortness of Breath ☐
Artificial Joint ☐	Excessive Thirst ☐	Joint Replacements _____	Sickle Cell Disease ☐
Asthma ☐	Fainting Spells / Dizziness ☐	Kidney Problems ☐	Sinus Trouble ☐
Back Problems ☐	Frequent Cough ☐	Lesion ☐	Skin Cancer _____
Blood Disease ☐	Frequent Diarrhea ☐	Leukemia ☐	Special Diet _____
Blood Transfusion ☐	Frequent Headaches ☐	Liver Disease ☐	Spina Bifida ☐
Breathing Problem ☐	Genital Herpes ☐	Low Blood Pressure ☐	Stomach Disease ☐
Bruise Easily ☐	Glaucoma ☐	Lung Disease ☐	Stroke _____
Cancer _____	Hay Fever ☐	Mitral Valve Prolapse _____	Swelling of Limbs ☐
Chemical Dependency ☐	Heart Attack _____	Nervous Problems ☐	Thyroid Disease ☐
Chemotherapy ☐	Heart Murmur ☐	Osteoporosis ☐	Tonsillitis ☐
Chest Pains ☐	Heart Pacemaker _____	Pain in Jaw Joints ☐	Tuberculosis ☐
Circulatory Problems ☐	Heart Trouble / Disease ☐	Parathyroid Disease ☐	Tumors or Growths ☐
Cold Sores / Fever Blister ☐	Hemophilia ☐	Psychiatric Care ☐	Ulcers ☐
Congenital Heart Disorder ☐	Hepatitis A ☐	Radiation treatments ☐	Venereal Disease ☐
Convulsions ☐	Hepatitis B or C ☐	Respiratory Disease ☐	Yellow Jaundice ☐

Have you ever had any serious illness not listed above? _____

Have you ever had any Surgery and date not listed above? _____

WOMEN ONLY:

Pregnant? _____ Due Date _____ Nursing? _____

Taking Birth Control Pills _____ Taking Hormonal Replacement _____

ALLERGIES:

Acrylic ☐	Clindamycin ☐	Iodine ☐	Morphine ☐
Amoxicillin ☐	Codeine ☐	Latex ☐	Penicillin ☐
Aspirin ☐	Epinephrine ☐	Local Anesthetics ☐	Sulfa Drugs ☐
Barbiturates ☐	Erythromycin ☐	Loratab ☐	Tetracycline ☐
Chlorhexidine ☐	Keflex ☐	Metal ☐	Tylenol ☐

Other Please explain _____

MEDICATIONS:

Are you taking any medications, pills, or drugs? If yes, please explain what medications are for:

_____

_____

_____

__ (Initial) To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

CONSENT FOR SERVICES:

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services performed without previous financial arrangements, must be paid for in full at the time services are performed.

Patients who carry dental insurance understand that all dental service furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumptions that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annually) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that the fee estimated listed for this dental care can only be extended for a period of 6 months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within 5 days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone, text message, email me at home or work to discuss matters related to this form. I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to use my photographs for in-office patient education.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

__ (Initial) INSURANCE: You are responsible for the entire balance of any treatment you receive. We will be glad to file your insurance electronically. Due to the large variety of insurance companies and plans, we are unable to determine the exact amount of coverage for each plan at the time of treatment. Your insurance coverage will be estimated and the remaining balance is due at time of treatment.

__ (Initial) MISSING APPOINTMENT / LATE CANCELLATION: Please give us the courtesy of 2 business days' notice if you are unable to make your appointment. If adequate notice is not given, a missed appointment or late cancellation charge will be applied to your account in the amount of $50.00 for each hour of time scheduled.

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic acts deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that the Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my defendants is mine, due and payable at the time services are rendered unless financial arrangements have been made in writing. I further understand that a 1.5% finance charge (18% annually) will be added to any balance over 60 days from when treatment was received. In event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient Signature _____ Date _____

Parent or Responsible Party _____ Relationship to Patient _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

Print Name _____

Signature _____

Date _____

_____

For Office Use Only

_____

We attempted to obtain written acknowledgement 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)