WELCOME TO OUR PRACTICE!

Thank you for choosing our office for your dental needs. Please take a few minutes to complete this confidential questionnaire so we may better serve you.

Date _____/ _____/ _____ Patient SS # _____ - _____- _____
Name _____ Birth date _____/ _____/ _____ Sex: M or F
Address _____ City _____ State _____ Zip _____
Please check one: ❑ Single ❑ Married ❑ Widowed
How did you learn about our office? _____

BILLING INFORMATION

Billing Name: _____ ❑ Self ❑ Spouse ❑ Parent ❑ Other _____
Billing Address (if different than home address)_____
City _____ Zip _____ Phone # at billing address (_____) _____-_____

CONTACT INFORMATION

Home (____) _____-_____Work (____) _____-_____Cell (____) _____-_____ Other (_ __) ____-_____

Spouse Work (_____) _____-_____ Spouse Cell (_____) _____-_____

Email Address: _____ Emergency Phone (____) _____-_____ Relationship to Patient _____

Would you prefer to be contacted by email/phone? List preferred phone # (___) _____- _____

INSURANCE INFORMATION

Insurance Company Name: _____

Address _____

Employer: _____

Employee SS # _____-_____-_____
Do you have secondary coverage? ❑ Yes ❑ No
Relationship to Patient: ❑ Self ❑ Spouse ❑ Child

ASSIGNMENT AND RELEASE DENTAL

I certify that I and/or my dependent(s), have insurance coverage with _____nd assign directly to Dr. _____ all insurance benefit, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(s) and their agents for the purpose of obtaining payment for services and determining Insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Rep. Relationship to Patient

It is important that we know about your medical and dental history. These facts have a direct bearing on your dental health.

What prompted you to seek dental care at this time? _____
Are you having any pain, discomfort or sensitivity at this time? If yes, please explain. _____
Are you nervous about receiving treatment? _____
Do you clench or grind your teeth? _____
Do you have pain in or around your jaw joints? If yes, please explain. _____

Reason for today's visit _____ Former Dentist_____
City/State _____ Date of last dental visit _____ X-rays _____ Cleaning ____
What did you enjoy or dislike about your prior dentist? _____
Place a mark on "yes" or "no" to indicate if you have had any of the following:

	YES	NO		YES	NO		YES	NO
Bad breath	❑	❑	Bleeding gums	❑	❑	Blisters on lips or mouth	❑	❑
Dry Mouth	❑	❑	Fingernail biting	❑	❑	Burning sensation on tongue	❑	❑
Tobacco use	❑	❑	Grinding teeth	❑	❑	Clicking or popping of jaw	❑	❑
Sensitivity	❑	❑	Ortho treatment	❑	❑	Gums swollen or tender	❑	❑
Jaw pain	❑	❑	Periodontal treatment	❑	❑	Loose teeth/broken fillings	❑	❑
Toothaches	❑	❑						
How often do you floss? _____ How often do you Brush? _____								

Have you ever been treated for periodontal disease? ___Have you ever had complications with tooth extraction? ___Do you use an electric toothbrush? ___ Are your teeth sensitive to hot and cold?___

IMMUNOSUPPRESSIVE CONDITION (CHECK ALL THAT APPLY)

❑ Steroid Therapy ❑ Organ Transplant ❑ Radiation or Cancer Therapy ❑ SLE (LUPUS)
❑ Rheumatoid Arthritis ❑ HIV ❑ No Spleen Function ❑ Other

ALLERGIES (CHECK ALL THAT APPLY)

❑ Latex ❑ Penicillin ❑ Aspirin ❑ Codeine ❑ Local Anesthetics ❑ Iodine ❑ Sulphur
❑ Barbiturates (Sleeping Pills) ❑ Other _____

DO YOU HAVE ANY DISEASE, CONDITIONS, OR PROBLEM NOT LISTED? IF YES, PLEASE EXPLAIN.

MEDICATIONS

Enter all of the prescription and over-the-counter medications you are currently taking.

NAME OF MEDICATION	DOSAGE	TIMES TAKEN/DAY	WHAT IS IT TAKEN FOR?

Pharmacy Name _____
Phone (_____) _____
Primary Care Physician's Name _____
City _____ Phone _____

Other Attending Physician's - Check all that apply.
Cardiologist ❑ OB/GYN ❑ Oncologist ❑

Name: _____
Phone: _____

What is the approximate date of your last physical:
Have you ever had surgery and /or been hospitalized for any reason other than normal labor and delivery:
Describe _____
Do you consider your health to be ❑ Excellent ❑ Good ❑ Fair ❑ Poor
Have you eve been told by your MD that you need pre-medication for any dental procedures? YES / NO

HAVE YOU EVER OR ARE YOU CURRENTLY TAKING MEDICATION FOR OSTEOPOROSIS? _____
Are you under the care of a M.D.?
ABOVE INFORMATION IS TRUE
Patient Signature _____ Date _____/_____/_____

CONSENT: I understand the above information is necessary to provide me with dental care in a safe and efficient manner. The undersigned hereby authorizes Dr. Adam Feret to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Adam Feret to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Adam Feret 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 Dr. Adam Feret choose and employ such assistance as deemed fit. 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 unless financial arrangements have been made. I further understand that a 1 1/2 % finance charge (18% annually) may be added to any balance held over 90 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and seasonable attorney fees as may be required to affect collection on this note.

PATIENT SIGNATURE_____ DATE_____/_____/_____

GUARDIAN SIGNATURE _____

RELATIONSHIP TO PATIENT _____

WITNESS _____

- IF THERE HAS BEEN ANY CHANGE IN YOUR ADDRESS, PHONE, INSURANCE OR BILLING INFORMATION, PLEASE INFORM A RECEPTIONIST. THANK YOU.

- NOTE: THE USE OF CELL PHONES IS NOT PERMITTED IN THE OPERATORIES??? AS IT INTERFERES WITH EQUIPMENT; KINDLY TURN OFF CELL PHONES PRIOR TO TREATMENT.

	YES	NO
BLOOD DISEASES		
ANEMIA		
EXCESS BLEEDING FOLLOWING A CUT, TOOTH EXTRACTION, ETC.		
ARTHRITIS OR RHEUMATISM		
FREQUENT FRACTURES		
JOINT PROSTHESIS/ ARTIFICIAL HIP		
SWOLLEN OR PAINFUL JOINTS		
HEART TROUBLE		
PAIN OR PRESSURE IN CHEST		
RHEUMATIC FEVER-HEART MURMUR		
MITRAL VALVE PROLAPSE		
SOAKING SWEATS WITH PROLONGED FEVER		
HIGH OR LOW BLOOD PRESSURE		
SHORTNESS OF BREATH		
FREQUENT NOSE BLEEDS		
STROKE		
THYROID, CORTISONE OR HORMONE TREATMENT		
DIABETES		
FAMILY MEMBERS WITH DIABETES		
DRY OR SWEATING SKIN		
WEAKNESS OR SLEEPINESS		
STOMACH OR INTESTINAL TROUBLE		
FREQUENT INDIGESTION, DIARRHEA, OR VOMITING PROBLEM		
APPETITE PROBLEM OR DIFFICULTY IN SWALLOWING		
LIVER TROUBLE, GALLBLADDER TROUBLE OR STONES		
ULCERS		
KIDNEY DISEASE		
SWOLLEN ANKLES OR EYELIDS		
BURNING OR PAIN IN URINATION		
FREQUENT URINATION		
DO YOU HAVE SLEEP APNEA?		
DO YOU DOZE OFF UNINTENTIONALLY?		
DO YOU OFTEN WAKE UP FEELING TIRED OR HAVING A HEADACHE?		
DO YOU HAVE PROBLEMS CONCEN-TRATING FOR LONG PERIODS OF TIME?		

	YES	NO
GONORRHEA		
SYPHILIS		
TUBERCULOSIS		
H.I.V./ H.P.V.		
HEPATITIS OR JAUNDICE		
HERPES		
NERVOUS OR MENTAL DISORDER		
EPILEPSY, CONVULSIONS OR FAINTING		
NEURITIS, NEURALGIA, OR NUMBNESS		
RESPIRATORY DISEASE		
CHRONIC STUFFY NOSE		
ASTHMA, HAY FEVER, OR ALLERGIES		
CHRONIC COUGH, HOARSENESS OR SORE THROAT		
BRONCHITIS OR EMPHYSEMA		
DIFFICULTY BREATHING		
TUMORS, GROWTHS, CYST OR CANCER		
RECENT GAIN OR LOSS OF WEIGHT		
SCARLET FEVER, PNEUMONIA, OR ANY OTHER HIGH FEVER		
MUMPS		
HAVE YOU TAKEN DIET MEDICATION ? (FEN-PHEN)		
SERIES OF NEEDLES OR INJECTIONS		
OPERATIONS OR HOSPITALIZATIONS		
TOBACCO USE (_____PACKS/DAY) SMOKELESS TOBACCO		
ALCOHOL ABUSE		
DRUG ABUSE		
REACTION TO PENICILLIN, OTHER ANTIBIOTICS OR ANESTHESIA		
HAVE YOU RECEIVED ANY TRANSFUSIONS?		
SKIN RASH, HIVES OR OTHER SKIN PROBLEMS		
FACIAL INJURIES		
EAR, EYE, NOSE OR THROAT PROBLEM		
SINUSITIS OR HEADACHES		

WOMEN ONLY

Yes	NO	Adult Women Only
		Are you pregnant? Due date:
		Are you nursing a baby: Baby's present age:
		Are you taking birth control pills?
		Have you reached menopause?
		Do you have breast implants?

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that your restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

Who else are we allowed to share dental diagnosis with?

Name: _____

Relationship to Patient: _____

OFFICE USE ONLY

I attempted to obtain the patients' signature in acknowledge on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initial _____ Reason _____

Insurance estimates are ONLY Estimations

As a courtesy to our patients, we will call your insurance for a breakdown of benefits and the information is reflected as your estimate. Unfortunately, your insurance carrier will NOT guarantee any information given to us; therefore, we cannot guarantee what percentage of your treatment will be covered. The patient is ultimately responsible for ALL charges incurred with our office should your insurance carrier not pay your claim. After 90 days, if your insurance has not paid for has made payment less than your total due amount, you are responsible for your account, and the remaining balance owed. The amount is due when notice is received by you. We strongly urge to call your insurance provider after 30 days and reiterate the need to pay on your account to avoid having to satisfy the account balance yourself.