Reset/Clear Form | Print Form

Welcome to Our Office

Please complete all information requested.

Patient Information

Name _____ Age ____ Sex ___ Home Phone (___)_____
First MI Last

Address _____ Apt. No. ____ Work Phone (___)_____

City _____ State ____ Zip _____ Pager/Cell (___)_____

Birth Date _____ SS# _____ Occupation _____

Full-time Student ☐ Yes ☐ No School Attending _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced

In case of emergency contact _____ Relationship _____ Phone (___)_____

Are any of your family members patients of this practice? ☐ Yes ☐ No Name _____

How did you hear about us? _____

If the person responsible for the account is different than the patient, please complete:

Name _____ Age ____ Sex ___ Home Phone (___)_____
First MI Last

Address _____ Apt. No. ____ Work Phone (___)_____

City _____ State ____ Zip _____ Pager/Cell (___)_____

Birth Date _____ SS# _____ Occupation _____

Relationship to patient _____

Primary DENTAL Insurance

Ins. Co. Name _____

Ins. Address _____

Ins. Phone (___)_____

Group Plan # _____

Effective Date _____

Insured Name _____

Address _____

_____

Date of Birth _____

Social Security # _____

Employer _____

Secondary DENTAL Insurance

Ins. Co. Name _____

Ins. Address _____

Ins. Phone (___)_____

Group Plan # _____

Effective Date _____

Insured Name _____

Address _____

_____

Date of Birth _____

Social Security # _____

Employer _____

Preferred Method of Payment

☐ Co-payment in full by Cash/Check

☐ Co-payment in full by VISA, MasterCard, Discover or Other Credit Source

Patient Treatment Consent

I authorize the Dentist(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me.

I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This form also authorized this practice to submit claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE." I authorize my Dentist(s) to release treatment records/x-rays or any other information deemed pertinent to my insurance carrier as necessary and/or requested.

I agree to be responsible for payment of all services rendered on myself and on my dependents. I agree that I am responsible for any unpaid claims. I have been made aware of all financial policies of the office.

Patient/Parent or Guardian Signature _____ Date _____

Medical History

Information that you feel insignificant could be directly related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all the questions in detail. Remember to include all information even if you do not think it to be important.

Patient's Name _____ Date _____

Do you have or have you ever been treated for:	Yes	No
Heart Failure	☐	☐
Heart Disease	☐	☐
Heart Attack	☐	☐
Heart Murmur*	☐	☐
Mitral Valve Prolapse	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
History of Fainting	☐	☐
Rheumatic Fever	☐	☐
Congenital Heart Lesions*	☐	☐
Scarlet Fever	☐	☐
Artificial Heart Valve*	☐	☐
Heart Pacemaker	☐	☐
Heart Surgery	☐	☐
Artificial Joint	☐	☐
Anemia	☐	☐
Hemophilia	☐	☐
Bleeding Disorders	☐	☐
Sickle Cell Trait	☐	☐
Blood Transfusion	☐	☐
Do You Smoke	☐	☐
Emphysema	☐	☐
Cough	☐	☐
Stroke	☐	☐
Tuberculosis	☐	☐
***Do you need to take antibiotic premedication prior to dental treatment?**	☐	☐

Name of antibiotic normally prescribed _____

Other _____

	Yes	No
Asthma	☐	☐
Hayfever	☐	☐
Sinus Trouble	☐	☐
Allergies or Hives	☐	☐
Diabetes	☐	☐
Thyroid Disease	☐	☐
Adrenal/Pituitary Problems	☐	☐
X-ray or Cobalt Treatment	☐	☐
Chemotherapy	☐	☐
Cancer or Leukemia	☐	☐
Arthritis	☐	☐
Rheumatism	☐	☐
Glaucoma	☐	☐
HIV/AIDS	☐	☐
Hepatitis A (Infectious)	☐	☐
Hepatitis B (Serum)	☐	☐
Hepatitis C	☐	☐
Hepatitis-Other	☐	☐
Liver Disease	☐	☐
Yellow Jaundice	☐	☐
Drug Addiction	☐	☐
Alcohol Addition	☐	☐
Sexually Transmitted Disease	☐	☐
Epilepsy or Seizures	☐	☐
Nervousness	☐	☐
Psychiatric Treatment	☐	☐
Phen/Fen Regimen	☐	☐

Allergic reaction (hives or swelling) to:

Acrylic	☐	☐
Penicillin	☐	☐
Erythromycin	☐	☐
Sulfa	☐	☐
Codeine	☐	☐
Aspirin	☐	☐
Local Anesthetic (Novocaine)	☐	☐
Latex	☐	☐

Other (i.e., fruits) _____

If you are female, are you:

Pregnant	☐	☐
Nursing	☐	☐
Taking Birth Control	☐	☐
Taking Hormone Medications	☐	☐

***WARNING:* Antibiotics reduce the effects of birth control pills.**

OB/GYN name, address, and phone _____

Do you have any current health problems not listed above?

If yes, list _____

Are you currently being treated by a physician?

If yes, list why _____

Date of last medical exam _____

Physician's name, address, and phone _____

Are you currently taking any medications, pills, or tonics? _____

List _____ For _____

List _____ For _____

List _____ For _____

Dental History

Reason for today's visit _____

Previous Dentist _____ Address or phone # _____

So that we can best serve you, may we ask why you left your last dental office? _____

_____

Date of last dental visit _____ Date of last dental exam _____ Date of last complete x-rays _____
(18 films or Panorex)

Date of last Prophy _____

Have you ever had any serious problems with past dental treatment? ☐ Yes ☐ No

If yes, explain _____

Do you have or have you ever been treated for:	**Yes**	**No**
Bad Breath	☐	☐
Bleeding Gums when Brushing/Flossing	☐	☐
Periodontal Treatment	☐	☐
Clicking or Popping Jaw	☐	☐
Grinding Teeth (Headaches)	☐	☐
Pain, Soreness of Facial Muscles	☐	☐
Food Collecting Between Teeth	☐	☐
Loose Teeth or Broken Filings	☐	☐
Sensitivity to Cold	☐	☐
Sensitivity to Hot	☐	☐
Sensitivity to Sweets	☐	☐
Sensitivity to Biting	☐	☐
Sores or Growths in Your Mouth	☐	☐
Do you have dental implants?	☐	☐
Are you happy with your smile?	☐	☐

I have provided accurate information to the best of my knowledge related to my medical and dental health.
I am responsible to inform the office of any changes in health history.

Patient Signature _____ Date _____
(If minor, parent or guardian)

Dentist _____ Date _____

Medical History Review and Update

Date _____ ☐ No change ☐ Change List Changes _____ New Medications _____

Patient's Signature _____ Dentist/Hygienist Signature _____

Medical History Review and Update

Date _____ ☐ No change ☐ Change List Changes _____ New Medications _____

Patient's Signature _____ Dentist/Hygienist Signature _____

Medical History Review and Update

Date _____ ☐ No change ☐ Change List Changes _____ New Medications _____

Patient's Signature _____ Dentist/Hygienist Signature _____

LAYHILL DENTAL CARE T/A **FAMILY DENTAL GROUP**

FINANCIAL POLICY

Dear (patient) _____

Thank you for selecting us as your dental health care provider. The following information describes our financial policy. Our primary goal is that you receive the optimal treatments needed to restore and maintain your dental health. Therefore, if you have any questions or concerns about our financial policies, please do not hesitate to ask us.

We ask that you read and sign our financial policy. Also, we ask that you complete our patient information form prior to seeing your dentist.

Payment for services is due at the time services are rendered. We accept personal checks, and for your convenience, MasterCard, VISA or Discover credit cards. We will help you process your insurance claim for your reimbursement if we have complete insurance information and if you bring a completed claim form with you to your next appointment. In special instances, we accept assignment of insurance benefits.

HOWEVER, please be aware:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our financial relationship is with YOU, and NOT your insurance company.
2. All charges are your responsibility whether your insurance company pays or not. Not all services are covered benefits in all contracts. Our financial relationship is with you, not your insurance company.
3. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.
4. If the insurance company does not pay your balance in full within thirty (30) days, we will ask that you contact the carrier to help speed things up.
5. If the insurance company does not pay your balance due, in full, within forty-five (45) days, we will require you to pay the remaining balance due with CASH, PERSONAL CHECK, MASTERCARD, VISA, or DISCOVER. Outstanding balances older than ninety (90) days may be subject to an eighteen percent (18%) APR interest charge and additional collection and or legal fees. Returned checks will have an additional fee of thirty dollars ($30.00) added to the check amount. A duplication fee of twenty-five dollars ($25.00) may be charged to copy an x-ray. You may request a copy of your record for an additional fee.
6. Please note that unless you cancel your appointment at least forty-eight (48) hours in advance, you may be charged for a missed appointment at the rate of our normal office visit. Please call the office as soon as possible if you have to reschedule.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us so that we can assist you in the management of your account.

Again, thank you for choosing LAYHILL / FAMILY DENTAL GROUP as your health care provider. We appreciate your confidence in us and the opportunity to serve you.

Patient's Signature _____ Date _____

Consent For Use And Disclosure of Health Information

Section A Patient Giving Consent

Name: _____

Telephone: _____ Email: _____

Section B To The Patient - Please Read The Following Carefully

Purpose of Consent: By signing this form, you are consenting to our use and disclosure of your Protected Health Information (PHI) to carry out Treatment, Payment activities and healthcare Operations (TPO).

With this consent, our office staff may call your home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as, but not limited to, appointment reminders, insurance/account items and information pertaining to your clinical care, including favorable laboratory results.

With this consent, our office staff may mail, or send via electronic mail (e-mail), to your home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and account or patient statements.

With this consent, you understand that this office WILL maintain a sign in sheet for all patients to sign upon arrival, however this sign in sheet will not list a reason for the visit. Additionally, schedules that include a patient's name may be posted throughout the office to assist the staff in healthcare operations, however the reason for the patient's visit will not be listed in a text that is readable to other patients.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of the uses and disclosures we may make of the treatment, payment activities, healthcare operations, and of other important matters concerning your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice or Privacy Practices including any revision to our notice at any time by contacting the office manager.

You have the right to request that our office staff restrict how it uses or discloses your PHI to carry out TPO. However, the practice is not required to agree to your requested restriction, but if it does, it is bound by this consent.

Signature: _____ Date: _____