Welcome to Fairview Family Dental

Patient Name: _____ Marital status: _____
First *MI* *Last*

Date of Birth*:* _____ /_____/_____ SSN: _____ Gender: _____

Home Address*:* _____
Street *City* *State* *Zip*

Email Address*:* _____

Phone #_____
Home *Work* *Cell*

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

Preferred method of payment: Cash_☐_ Check _☐_ Credit Card _☐_ Care Credit_☐_

In case of emergency_____ Phone #_____ Relationship_____

Dental Insurance Information

Does Patient have dental insurance? *Y*_☐ *N*_☐

Primary Insurance Company: _____

Address: _____Phone #_____

Policy holder name: _____Relationship: _____

Date Of Birth: _____/_____/_____ Employer*:* _____

ID#_____ Group #_____
SSN or Policy ID #

Secondary Insurance Company: _____

Address: _____ Phone #_____

Policy holder name: _____Relationship: _____

Date Of Birth: _____/_____/_____ Employer*:* _____

ID# _____ Group# _____
SSN or Policy ID #

Authorized Signature on File: I hereby authorize the doctor and staff to affix my signature on any insurance or referral form for myself and family, and the release of information relative to dental records for insurance claims and doctor referrals.

*Signature:*_____ *Date:* _____

MEDICAL/ DENTAL HISTORY

What is your goal for today's visit? (ie. Routine dental visit, smile improvement, implants, etc.)
_____

Date of last dental visit: _____ / _____ / _____ Last cleaning: _____ / _____ / _____

Name & phone number of previous dentist: _____

Family Physician's name: _____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Abnormal Bleeding	**Yes ☐ No ☐**	**Kidney Disease**	**Yes ☐ No ☐**
Asthma	**Yes ☐ No ☐**	**Lung Disease**	**Yes ☐ No ☐**
Cancer/Tumors	**Yes ☐ No ☐**	**Pacemaker**	**Yes ☐ No ☐**
Diabetes	**Yes ☐ No ☐**	**Pain in jaw/TMJ**	**Yes ☐ No ☐**
Epilepsy/Seizures	**Yes ☐ No ☐**	**Radiation Therapy**	**Yes ☐ No ☐**
Heart Disease	**Yes ☐ No ☐**	**Sinus Problems**	**Yes ☐ No ☐**
Hepatitis A	**Yes ☐ No ☐**	**Stroke**	**Yes ☐ No ☐**
Hepatitis B or C	**Yes ☐ No ☐**	**Thyroid Disease**	**Yes ☐ No ☐**
High Blood Pressure	**Yes ☐ No ☐**	**Tobacco Use**	**Yes ☐ No ☐**
HIV / Aids	**Yes ☐ No ☐**	**Tuberculosis**	**Yes ☐ No ☐**

Joint Replacement? **Yes ☐ No ☐** If Yes, what joint and when? _____
If female, are you Pregnant? **Yes ☐ No ☐** How many weeks? _____

Have you been hospitalized in the last 5years? **Yes ☐ No ☐**
If yes, please explain: _____

Any history of adverse reactions to an antibiotic? **Yes ☐ No ☐**
If yes, please explain: _____

Allergies? **Yes ☐ No ☐**
If yes**,** please list: _____

Have you ever taken a medicine for bone density i.e. Bisphosphonate therapy? **Yes ☐ No ☐**
If yes, what kind and when? _____

Do you take a blood thinner? **Yes ☐ No ☐**

Have you ever been told you have gum disease or had Scaling and Root Planing? **Yes ☐ No ☐**

Do you have any physical condition not listed above or are you receiving any other health care we should be made aware of? **Yes ☐ No ☐**
If yes, please give us details: _____

Are you currently taking any medications, including vitamins or supplements? **Yes ☐ No ☐**
If yes, please list name and dosage: _____

_____

Name (Printed): _____

Signature: _____ *Date:* _____*rev 01/23*

Office Policies

Insurance & Payments

Our office is glad to file your insurance claims as a service to you. Since we do not have access to your individual policy, we cannot guarantee payment from your insurance company. We will do our best to advise you as treatment is diagnosed but we assume no liability. It is your responsibility to review your insurance policy and benefits. All co-payments and deductibles are due at the time of service. If your insurance company pays less than what our office has estimated, **the balance is your responsibility** and must be paid within 90 days. For your convenience, our office accepts Visa, MasterCard, Discover, check, cash and debit. We also have a financing option through Care Credit for your convenience.

Any accounts over 30 days past due are subject to $10.00 per month finance charge. **Any account that becomes over 90 days past due will be referred to a collection agency, which will affect your credit report, and you will be dismissed from the practice.**

By signing below, I acknowledge that this account is my responsibility regardless of what my insurance covers. My portion is due at the time services are rendered.

Communications Consent

By signing below, you agree to receive electronic communication via text and/or email by us which is our primary method of confirming your appointments.

Cancellation Policy

In event of a cancellation, I understand that I am required to give the office no less than 24 hours notice. **If I fail to give 24 hours notice, I will be charged a cancellation fee.** If I cancel or miss three appointments, **I understand I may be dismissed from the practice** and my records will be sent to a dentist of my choosing.

I HAVE READ AND THOROUGHLY UNDERSTAND THE OFFICE POLICIES, COMMUNICATIONS CONSENT AND CANCELLATION POLICIES.

Signature: _____ *Date:*_____

OFFICE USE ONLY:

Primary identification:_____

Secondary identification:_____***Rev 5/23***

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Fairview Family Dental

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 have received, read and understand 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 you 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: _____

OFFICE USE ONLY

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

Date: Initials: Reason: