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FAIRVIEW
FAMILY DENTAL, P.C

PATIENT INFORMATION

Patient Name: _____ Preferred Name: _____
First MI Last

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

Address: _____
Street City State ZIP

Email Address: _____ Marital Status:

Phone: _____
Home Work Cell

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

Emergency Contact: _____ Phone: _____ Relationship: _____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance Company: _____

Address: _____ Phone: _____

Policy Holder Name: _____ Relationship: _____

Date of Birth: ____/____/____ Employer: _____

ID #: _____ Group #: _____
SSN or Policy ID #

Secondary Dental Insurance Company: _____

Address: _____ Phone: _____

Policy Holder Name: _____ Relationship: _____

Date of Birth: ____/____/____ Employer: _____

ID #: _____ Group #: _____
SSN or Policy ID #

Authorized Signature on File: I give my permission for the doctor and staff to use my signature on any insurance or referral forms for me and my family. I also allow the release of dental information as needed to help with insurance claims and referrals to other healthcare providers.

Signature: _____ Date: _____

MEDICAL AND DENTAL HISTORY

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

_____

_____

Name of previous dentist: _____ Phone: _____

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

Family Physicians (PCP) Name: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

Do you have or have you ever had any of the following? (Please answer all)

Abnormal Bleeding	Kidney Disease
Asthma	Lung Disease
Cancer/Tumors	Pacemaker
Diabetes	Pain In Jaw/TMJ
Epilepsy/Seizures	Radiation Therapy
Heart Disease	Sinus Problems
Hepatitis A	Stroke
Hepatitis B or C	Thyroid Disease
High Blood Pressure	Tobacco Use
HIV/AIDS	Tuberculosis

Joint Replacement? If yes, what joint and when? _____

Any heart procedures? If yes, when and what procedures? _____

Do you take Pre-Medication for dental procedures?

Are you pregnant? If yes, how many weeks? _____

Have you been hospitalized in the last 5 years?

If yes, please explain: _____

Do you have a history of averse reactions to an antibiotic?

If yes, please explain: _____

Do you have any allergies?

If yes, please explain: _____

Have you ever taken a medicine for bone density i.e. Bisphosphonate therapy?

If yes, what kind and when: _____

Do you take a blood thinner?

Have you ever been told you have gum disease or had Scaling and Root Planing?

Do you have a physical condition not listed above or are you receiving any other health care we should be aware of?

If yes, please explain: _____

Please list any current medications, including vitamins and supplements: _____

_____

_____

Name (printed): _____

Signature: _____ Date: _____

OFFICE POLICIES

Insurance and Payments

As a courtesy to our patients, our office is happy to file insurance claims on your behalf. However, please note that we do not have access to the specific details of your individual insurance policy and therefore cannot guarantee coverage or payment from your insurance provider. While we will make every effort to provide you with an accurate estimate based on the information available at the time of diagnosis, ultimate responsibility for understanding your insurance benefits lies with you.

Payment is due in full at the time of service. For your convenience, we accept Visa, MasterCard, Discover, debit cards, checks, and cash. Financing options are also available through CareCredit.
Accounts with balances over 90 days past due will incur a ***$10.00 monthly finance charge.***
Accounts exceeding 90 days past due may be referred to a collection agency, which may impact your credit report and result in dismissal from the practice.

By signing below, I acknowledge that I am financially responsible for this account, regardless of insurance coverage. I agree to pay my portion at the time services are provided.

Communications Consent

By signing below, I consent to receive electronic communications via text message and/or email. This will serve as our primary method for confirming appointments and providing important updates related to your care

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I HAVE READ AND UNDERSTAND INSURANCE AND PAYMENTS POLICIES, AND COMMUNICATIONS AND CONSENT POLICIES

Signature: _____ Date: _____

Cancellation Policy

We understand that sometimes unexpected situations arise and you may not be able to keep your appointment. As a courtesy to our team and other patients, we kindly ask that you provide at least **48 hours** notice if you need to cancel or reschedule. This allows us to offer that time to another patient who may be waiting for care.

To keep our schedule running smoothly and ensure that all patients are able to receive the care they need, our office has the following policies:

- **New Patient Appointments**
  - Failure to arrive for a scheduled new patient appointment will result in dismissal from the practice
  - Rescheduling a new patient appointment more than once will also result in dismissal
- **Cancellations and Missed Appointments**
  - Same-day cancellations may be subject to a cancellation fee
  - Three late cancellations or missed appointments may result in dismissal from the practice
- **Records Transfer**
  - In the event of dismissal, we will gladly forward your dental records to the provider of your choice upon request.

As a reminder, our office provides ***confirmation calls and text reminders*** as a courtesy to help you keep track of upcoming appointments or reschedule in a timely manner.

By signing below, you acknowledge that you have read and understand our cancellation policy. You also understand that failure to comply with these policies may result in dismissal from the practice at the discretion of your provider.

I HAVE READ AND UNDERSTAND THE ABOVE CANCELLATION POLICY

Signature:_____ Date: _____

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 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: