Patient Information

Please Print **Date**: _____

Patient Name: _____ ___ _____ _____
First MI Last Preferred Name

Address: _____ _____ ___ _____
City State Zip Code

Phone: _____ _____ _____ SSN: _____
Home Work Cell

Birth Date: _____ Gender (Circle): **M** **F** Employer:_____

Email: _____ Family Status: ☐Child ☐Single ☐ Married ☐Other

If Married:_____ _____ If Child: _____
Spouse's Name Spouse's Date of Birth Parent / Guardian Name

Whom may we thank for referring you to our practice?
☐ Duff Family Dental Website ☐ Online Reviews ☐ Insurance ☐ Other_____

Dental Insurance Information

Do you have Dental Insurance? (circle) Yes No ***WE DO NOT FILE SECONDARY INSURANCE***

Subscriber Name	
Subscriber SSN	
Subscriber Date of Birth	
Relationship to Subscriber	☐ Self ☐ Spouse ☐ Child ☐ Other
Employer Name	
Employer Phone Number	
Insurance Company Name	
Insurance ID Number	
Insurance Group Number	
Insurance Phone Number	

Please present insurance card to the receptionist to be photocopied

I AUTHORIZE PAYMENT OF DENTAL BENEFITS TO BE PAID DIRECTLY TO THE PROVIDER; IF I DO NOT HAVE INSURANCE I UNDERSTAND I AM RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE.

Information on this form is kept confidential

Medical History

Are you currently under the care of a physician? ___Yes ___ No
-If you answered yes: What is the physician's Name? _____ & Phone: _____

Have you had a serious illness, operation or been hospitalized in the past 5 years? ___Yes ___No
-If yes, what was the illness or problem? _____

Are you taking or have you recently taken an prescription or over the counter medicines? ___Yes ___No
-If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:
_____
_____
_____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ___Yes ___No
-If yes, Name of Physician or Dentist making recommendation: _____ *Phone:*_____

Women are you: Pregnant___ / Trying to get pregnant ___ / Nursing ___ / Taking Contraceptives___

Are you Allergic to any of the following:
Aspirin ___ Penicillin ___ Codeine___ Acrylic ___ Metal ___ Latex ___ Local Anesthetics___ Animals ___ Food ___
Amoxicillin ___ Sulfa ___ Other (Please List):_____

Joint Replacement
Have you had an orthopedic total joint (knee, elbow, hip, finger) replacement? ___Yes ___No
-If yes, have you had any complications? _____ Date of Operation: _____

Do you have or ever had any of the following:

___AIDS/HIV Positive	___Emphysema	___Hives or Rash	___Spina Bifida
___Alzheimer's Disease	___Epilepsy/Seizures	___Hypoglycemia	___Stroke
___Anemia	___Excessive bleeding	___Kidney Disease	___Swelling
___Arthritis/Gout	___Fainting/Dizziness	___ Leukemia	___Thyroid Disease
___Artificial Heart Valve*	___Frequent Headaches	___ Liver Disease	___Tonsillitis
___Artificial Joints*	___Herpes Simplex	___ Low Blood Pressure	___Tuberculosis
___Asthma	___Glaucoma	___ Lung Disease	___Tumors
___Blood Disease	___Hay Fever/Allergies	___Mitral Valve Prolapse*	___Ulcers
___Blood Transfusion	___Heart Attack/Failure	___ Renal Dialysis	___Sleep Disorder
___High Blood Pressure	___Heart Disease	___ Rheumatic Fever*	___Eating Disorder
___Chemotherapy	___Heart Murmur*	___ Scarlet Fever	___Diabetes (Type: _____)
___Cold Sores/Fever Blister	___Hemophilia	___ Shingles	___Cancer (Type:_____)
___Congenital Heart Disorder	___Hepatitis A, B, or C	___ Sickle Cell Disease	___Sinus Problems

Have you ever had any serious illness not listed? ____ Yes ____ No
PleaseExplain:_____
_____

Patient Dental History:

Do your gums bleed while brushing or flossing?	__Yes __No	Do you clench or grind your teeth?	__Yes __No
Are your teeth sensitive to hot/cold liquid or food?	__Yes __No	Prolonged bleeding after extractions?	__Yes __No
Do you feel pain in any of your teeth?	__Yes __No	Have you had any orthodontic treatment?	__Yes __No
Have you had any head, neck, or jaw injuries?	__Yes __No	Do you wear dentures or partials?	__Yes __No
Do you like your smile?	__Yes __No	Do you have frequent headaches?	__ Yes __No
Would you like your teeth to look whiter?	__Yes __No	Do you have clicking or pain in your jaw?	__ Yes __ No
Do you have a dry mouth typically?	__ Yes __No	Do you Snore?	__Yes __No

Are you currently experiencing any dental pain or discomfort? _____
How long has it been since your last dental visit? _____

Authorization and Consent:
I certify that I have read and understand the above information to the best of my knowledge and have accurately answered. I understand that providing the incorrect information can be dangerous to my health. I give my consent to be seen by the doctor and if I elect treatment, I consent for the work to be done and understand that during the course of the procedure(s) unforeseen conditions may occur which necessitate procedures other than contemplated. I am aware there may be additional charges.

Signature of Patient / Legal Guardian: _____ Date: _____

Office Policies

Quality care for our patients is our top priority. Please take a moment to review our office policies and sign at the bottom of this form. If you have any questions please let us know.

No-Show Policy

Definition of a "No-Show" Appointment: Any scheduled appointment in which the patient either: Does not arrive to the appointment OR Cancels with less than 24 hours' notice

Impact of a "No-Show Appointment

"No-Show" appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient "no-shows" a scheduled appointment it:

-Potentially jeopardizes the health of the "no-showing" patient

-Is unfair (and frustrating) to other patients that would have taken the appointment slot

-Disrespects not only the providers time, but also the time of the entire clinic staff

Consequences of "No-Show" Appointments

If you miss 3 or more appointments within a year you may be dismissed from the clinic. If you are dismissed from the clinic, your remaining scheduled appointments will be cancelled and only emergency dental treatment will be offered within the first 30 days of dismissal. Duff Family Dental reserves the right to charge and collect fees for "No-Show" appointments

Dental Insurance

Insurance benefits are determined by your employer and not your dentist. ***Any deductible or estimated co-payment amounts will be due at the time of treatment***. We only provide estimates using your dental insurance, any amount not covered by your insurance will be your responsibility. As a courtesy we will be glad to file your claim to your insurance. You will be expected to pay for services rendered if the office is unable to verify your insurance information before treatment.

Payment Policy

A written treatment plan will be provided and options will be discussed with you. We live by the golden rule of "treat others as you would like to be treated," so only the optimal treatment will be prescribed. For your convenience, we accept: Cash, Visa, Master Card, Discover, Care Credit, Lending Club, American Express and personal checks.

Over Due Balances and Collections

We understand temporary financial problems arise. We encourage you to communicate any such problems immediately so we may assist you in the management of your account and avoid sending your account to collections. An account with an unpaid balance past 90 days will be sent to the collection agency. At that time, you will be responsible for any and all cost incurred in the collection of your debt.

HIPAA:

I have received and acknowledged the Notice of Privacy Practice (See attached) and consent for use and disclosure of health information.I give this practice consent to use or disclose my health information to carry out treatment, obtain insurance payments and health care operations.

I have read and understand the office policies.

Signature: _____ Date: _____

Printed Name: _____