DUFF FAMILY DENTAL

Welcome to our practice!

Will you please help us by providing the following confidential information?

Patient Information:

Last Name: _____ First Name: _____

Email Address: _____ Preferred to be called: _____

Date of Birth: _____ Gender: M / F (circle one) SSN#: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Street Address: _____ City, State, Zip: _____

Driver's License #: _____ Employer: _____

Emergency Contact Name: _____ Phone: _____ Relation: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

How did you hear about our office: Online Patient Referral Website Other: _____

If you were a referral, whom may we thank for their trust in us? _____

Dental Insurance Information:

Insurance Company: _____ Phone #: _____

Policy Holder Name: _____ Member ID or SSN: _____

Policy Holder Date of Birth: _____ Group #: _____

I hereby authorize the release of any information to my insurance company or companies, including records of examination, diagnosis and/or treatment. This release is solely for facilitating the billing and reimbursement, directly to Duff Family Dental of insurance benefits under which I am entitled. **I hereby agree that I am financially responsible for all treatment rendered** and understand that complete payment will be made after each treatment unless other financial arrangements have been previously arranged.

Consent:

I hereby authorize Duff Family Dental to take necessary x-rays, study models, photographs or any other diagnostic aids deemed appropriate by Duff Family Dental to make a thorough diagnosis of the patient's dental needs, lab needs, and for the use of dental education, which may include full face or smile photos. I also authorize Duff Family Dental to perform all forms of treatment, medication and therapy that may be indicated and understand the use of anesthetic agents embodies a certain risk. **I understand that my dental insurance is a contract between me and insurance carrier and not between Duff Family Dental and the insurance company. I fully understand that it is my financial responsibility only, for all dental treatment regardless of insurance coverage.**

Date: _____ Patient Signature: _____

Medical History:

Are you currently under the care of a physician? Yes or No
If yes, what is the physicians name? _____ Date of Last Medical Exam: _____

Have you had a serious illness, operation or been hospitalized in the past 5 years? Yes or No
If yes, what was the illness, operation, or hospitalization for?
_____
_____

WOMEN: Are you currently pregnant? Yes or No Taking Contraceptives? Yes or No

Are you taking any prescriptions or over the counter medications? Yes or No
If yes, please list all medications including vitamins and supplements:
_____
_____

Are you Allergic to any of the following? (Please check mark or place and x on the line to the right)
Aspirin___ Penicillin___ Codeine___ Acrylic___ Metal___ Latex___ Local Anesthetic___ Amoxicillin___ Sulfa___
Other (please list) _____

Joint Replacement
Have you had an orthopedic total joint (knee, elbow, finer, hip) replacement? Yes or No
If yes, have you had any complications? _____ Date of Operation: _____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes or No
If yes, what is the name of the physician or dentist making recommendation? _____

Do you have or ever had any of the following (check mark or place an x in the box to the right):

AIDS/HIV		Blood Transfusion		Frequent Headaches		Hepatitis A, B, or C		Mitral Valve Prolapse		Swelling	
Alzheimer's Disease		High Blood Pressure		Herpes Simplex		Hives or Rash		Renal Dialysis		Thyroid Disease	
Anemia		Cold Sores/Fever Blister		Glaucoma		Hypoglycemia		Rhematic Fever		Tonsillitis	
Arthritis/Gout		Congenital Heart Disorder		Allergies		Kidney Disease		Scarlet Fever		Tuberculosis	
Artificial Heart Valve		Emphysema		Heart Attack		Leukemia		Shingles		Tumors	
Artificial Joint		Epilepsy/Seizures		Heart Disease		Liver Disease		Sickle Cell Disease		Ulcers	
Asthma		Excessive Bleeding		Heart Murmur		Low Blood Pressure		Spina Bifida		Sleep Disorder	
Cancer		Eating Disorder		Diabetes		Sinus Problems		Bells Palsy		Depression	
Blood Disease		Fainting/Dizziness		Hemophilia		Lung Disease		Stroke		Multiple Sclerosis	

Have you ever had a serious illness that is not listed? Yes or No
If yes, please explain:
_____

Are you currently using any type of tobacco? Yes or No (Type: _____)

Do you take or have you taken any recreational drugs or have a history of substance abuse? Yes or No

Dental History:

Former Dentist: _____ **How long since last visit**: _____

Have you experienced any of the following?

Yes or No Bleeding Gums
Yes or No Bad breath or sour taste in mouth
Yes or No Burning sensation in mouth
Yes or No Soreness in jaw
Yes or No Clicking or popping in jaw
Yes or No Do you wear a partial or denture?
Yes or No Does having dental treatment make you nervous. If yes, why?
_____

Yes or No Sensitivity to hot and/or cold? If yes, to hot, cold or both? _____
Yes or No Snoring?
Yes or No Food catching between teeth
Yes or No Clenching or grinding of teeth?
Yes or No Prior orthodontic treatment (Ex: Braces or Invisalign)

If you could change anything about your smile which of the following, would you want?

Yes or No Whiter
Yes or No Replace missing teeth
Yes or No Straighter
Yes or No Close space or spaces
Yes or No Replace old crowns

Other (please list:)
_____

Are you experiencing any current dental problems? If yes, please explain:
_____
_____
_____

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.

Date: _____ Patient Signature: _____

Office Policies and Payment Agreement

Please initial each statement:

_____ I understand that Duff Family Dental does bill my insurance, if available, and any amount not covered by my insurance is the full responsibility of the patient/guarantor of the said account.

_____ I understand that co-payments and/or deductibles, as estimated by any Duff Family Dental employee, are due prior to treatment commencing or as otherwise stated on this page. Patient co-payments are an estimate of insurance benefits only and not a guarantee of payment. Payment of insurance benefits are subject to all terms, conditions, limitations, and exclusions of your insurance at the time services are completed. I also understand some treatment may be above the insurance contracted fee and/or go beyond my yearly maximum dental benefits and this is an agreement between myself, and Duff Family Dental and I am responsible for these fee's. If my contract is terminated or I have not updated my insurance company/coverage with Duff Family Dental, I am fully responsible to pay for all fees incurred.

_____ I understand that my employer or 3rd party negotiated my insurance contract, not Duff Family Dental or its employees. If I have a dispute with my insurance company, I will inform my employer and/or my insurance company.

_____ In the event of upgraded treatment, including but not limited to Emax porcelain and/or any and all upgraded porcelain, lab fees, etc. I understand and accept that these upgraded fee's will not be covered by insurance, and I agree to pay for these fees as presented to me by Duff Family Dental.

_____ I understand that in some cases during a procedure, the treatment plan may change, and I may incur additional costs. I also understand that I will be informed of this change during the procedure, and I understand I will be responsible for any added cost of the changed treatment.

_____ I understand I will receive a detailed estimate for needed treatment and appointments. These payments are due at time of service.

_____ Duff Family Dental reserves the right to charge a $25.00 fee for cancellations and no-show appointments.

_____ I understand the above statements and that I am responsible for all fees incurred in this office whether I have insurance coverage or not.

_____ I understand that I have the right to access the Notice of Privacy Practices (printed copies can be provided.) I consent for the use and disclosure of health information. I give Duff Family Dental consent to use or disclose my health information to carry out treatment, obtain insurance payments and health care operations.