Patient Information Form

Bull Shoals Family Dental

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Mailing Address: _____
Street or P.O. Box City/State Zip code

Sex (M or F): ____ Marital Status: ____ Birth Date: _____

Phone (Home): _____ Phone (Work): _____ Cell: _____

DL#: _____ State: _____ Email _____

Are any other immediate family members patients here? _____If so, who?_____

Responsible Party

Person responsible for the account _____ Relationship _____

Social Security Number_____ DOB_____ Phone Number_____

Mailing Address _____
Street/P.O. Box City/State Zip code

Signature_____ **Date**_____

Dental Insurance Authorization

If you have dental insurance, please provide us with the active dental insurance card.
We cannot accept or bill medical insurance or medicare

I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____ **Date**_____

Consent for Services and Financial Policy Patient Name_____

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate for this dental care can only be extended for a period of 3 months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I grant my permission to you or your assignee, to telephone/text me to confirm appointments, discuss this statement or my treatment.

I authorize the staff to perform any necessary services needed during diagnosis and treatment.

Signature_____ Date_____

Phone_____ Address_____

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I allow this practice to disclose my Protective Health Information to the following individuals: (This information could include: Name, Diagnosis, Test Results, Images and Account Information.) I authorize the staff to share information with other physicians as necessary.

I authorize the staff of Bull Shoals Family Dental to release information to the following:

1._____

Name Relationship Phone #

2._____

Name Relationship Phone #

3._____

Name Relationship Phone #

I have read and understand the above information and agree with its contents.

Signature_____ Date_____

Patient Name_____ **Date**_____

Health Information (check all that apply)

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

☐ Acid Reflux	☐ ADHD	☐ Allergies-Seasonal	☐ Allergy Amoxicillin
☐ Allergy Asprin	☐ Allergy Clindamycin	☐ Allergy Codeine	☐ Allergy Epinephrine
☐ Allergy Hydrocodone	☐ Allergy Keflex	☐ Allergy Latex	☐ Allergy Nickel
☐ Allergy Penicillin	☐ Allergy Sulfa Drugs	☐ Allergy Tylenol	☐ Anemia
☐ Anxiety/Panic attack	☐ Arthritis	☐ Artificial Joints	☐ ArtificialHeartValve
☐ Asthma	☐ Auto Immune Disease	☐ Bipolar	☐ Blood Thinner
☐ Cancer-active	☐ Cancer-Treated/Free	☐ Cerebral Palsy	☐ COPD
☐ CPAP user	☐ Dementia	☐ Depression	☐ Diabetes
☐ Dizziness	☐ Epilepsy	☐ Fainting	☐ Fever Blisters
☐ Fibromyalgia	☐ Glaucoma	☐ Head Injuries	☐ Heart Attack
☐ Heart Disease	☐ Hepatitis	☐ High Blood Pressure	☐ High Cholesterol
☐ HIV/AIDS	☐ Kidney Disease	☐ Liver Disease	☐ Mental Disorders
☐ Migranes	☐ Nervous Disorders	☐ Nightguard User	☐ Osteoporosis
☐ Pacemaker	☐ Pregnancy/Nursing	☐ PTSD	☐ Radiation Treatment
☐ Respiratory Problems	☐ Rheumatic Fever	☐ Seizures	☐ Sinus Problems
☐ Sleep Apnea	☐ Smoke Tobacco	☐ Smokeless Tobacco	☐ Stomach Problems
☐ Stroke	☐ Thyroid disease	☐ TMD/TMJ disorder	☐ Tuberculosis
☐ Tumors	☐ Ulcers-oral	☐ Ulcers-stomach	☐ Venereal Disease

***Please list any other **medical condition, allergy, surgery, treatment or disease**:

_____

_____

_____

***Preferred Pharmacy:** _____

***List all **medications** you currently take (including Over The Counter drugs/supplements) **or** provide a list

_____

_____

_____

Referral Information

How were you referred to our practice? Please check one
___Another Patient (Who may we thank for the referral?) Name: _____
___Online search
___Website
___Insurance
___Phone Book
___Other (please let us know how you heard about us): _____

Personal Information

Briefly tell us about yourself (if you would like):_____

_____

Have you ever had a bad experience at the dentist? _____

When was your last dental visit? _____What is the reason for this visit? _____

Previous dentist's name and address: _____

Why did you leave your previous dentist? _____

When were X rays last taken of your teeth? _____

How frequently do you brush your teeth? _____ Soft or Hard bristle toothbrush? _____

Yes	No	Any concerns regarding your teeth?	Yes	No	Have you lost any teeth?
Yes	No	Do you clench or grind your teeth?	Yes	No	Any tooth or jaw discomfort?
Yes	No	Do you have snoring or sleeping issues?	Yes	No	Have a click or pop in your jaw joint?
Yes	No	Are your teeth sensitive to hot or cold?	Yes	No	Any teeth uncomfortable to bite on?
Yes	No	Interested in teeth whitening?	Yes	No	Gums bleed when brushing or flossing?
Yes	No	Do you like your smile?	Yes	No	Do you smoke or use tobacco?

Are there any conditions or concerns about your health that we need to discuss that have not been covered

in this questionnaire? _____

_____