Bird Family Dentistry

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PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT INFORMATION

Chart#: _____
FOR OFFICE USE ONLY

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

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ Website ☐ Facebook ☐ Phonebook ☐ Office Sign ☐ Referred by a friend

If referred by a friend please list their name so we can thank them.

_____

_____

Emergency Information

Who should we call in case of emergency? Relationship and Telephone Number.

_____

_____

PERSON FINANCIALLY RESPONSIBLE (click neither if patient is responsible)

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **Email Address:** _____

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

FINANCIAL POLICY

Payment for dental treatment is due at the time of treatment. We do not offer any "in office" payment plans.
Occasionally, accounts become delinquent. We assign past due accounts to our collection service. This can be avoided by keeping in contact with us; we do not want this action any more than you do. Unpaid balances will be subject to a late fee service charge of 1% per month, at 12% APR, after 60 days.

Having a full and productive schedule helps us to maintain our standard of top quality dental care and to keep our fees reasonable for our patients. The charge for a "no show" or appointment cancelled with less than 24 hours notice is $50 and must be paid before your next appointment will be scheduled.

PRIMARY DENTAL INSURANCE

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Bird Family Dentistry will submit your dental claim electronically to your insurance company on your behalf. Please check with your insurance company for a full benefit summary so you can be informed about your dental insurance prior to your appointment. Insurance estimates are not a guarantee of payment so if your insurance company pays less than expected you are responsible for the difference. We do collect your patient portion at the time of service unless other arrangements have been made with our Office Manager. If you have any questions about your dental insurance please call your insurance company or your human resources department at your employer.

SECONDARY DENTAL INSURANCE

Name of Insured: _____ _____ _____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

HIPAA NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGEMENT

☐ * **By checking this box I acknowledge that I have read the following statement and agree to the contents.**

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting any of our staff members.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

CONSENT FOR TREATMENT

1. I herby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.

2. Upon such a diagnosis, I authorize doctor to perform all mutally agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1% finance charge (12% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Responsible Party Name (or Parent for Minor Children): *

Relationship to Minor Child: _____

Medical and Dental History

Current physician name, address, telephone number.

Please list all current medications.

Please check all that apply:

- ☐ *Pre-Med - Amox
- ☐ *Pre-Med - Clind
- ☐ *Pre-Med - Other
- ☐ Allergies
- ☐ Allergy - Aspirin
- ☐ Allergy - Codeine
- ☐ Allergy - Erythro
- ☐ Allergy - Hay Fever
- ☐ Allergy - Latex
- ☐ Allergy - Other
- ☐ Allergy - Pen/Amox
- ☐ Allergy - Sulfa
- ☐ Allergy-Keflex(cepha
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Caution with Epi
- ☐ Coumadin/Warfarin
- ☐ Dental Anxiety
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Fosomax
- ☐ G.E.R.D/Acid Reflux
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hep A
- ☐ Hep B
- ☐ Hep C
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Hx Substance Abuse
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ N2O
- ☐ Nervous Disorders
- ☐ No Epinephrine
- ☐ Other
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers

If further explanation is needed or if you checked other, please respond below:

Have you had any recent surgeries or hospital visits? Please explain:

Do you drink alcohol? ◯ Yes ◯ No

If yes, how much and how often?

Do you use any tobacco products? ◯ Yes ◯ No

If yes, please describe what and how often.

Women Only

Are you taking contraceptives or other hormones? ◯ Yes ◯ No

Are you pregnant or nursing? ◯ Yes ◯ No

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