

Patient Information

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us-we are happy to help.

ABOUT YOU

Name: _____ I prefer to be called: _____ { }Male { }Female

Marital Status: { }Single { }Married { }Divorced { }Widowed { }Child Children? { }Yes { }No

Date of Birth: ____/____/____ Age: ____ SSN ____-____-____ DL# _____

Home Address: _____ Home Phone: _____

Cellular Phone: _____ Work Phone: _____ E-Mail: _____

May we contact you concerning appointments and your dental health via: { }Text Messaging { }E-Mail

Employer/Job Title: _____ How long employed: _____

Student Status { }Part time { }Full Time School Name: _____

Whom may we thank for referring you? { }Phone Book { }Website { }Social Media
{ }Current Patient _____ { }Other _____

SPOUSE INFORMATION

Name: _____ Date of Birth: _____

Employer/Job Title: _____ Work Phone: _____ ext _____

PERSON RESPONSIBLE FOR ACCOUNT

{ }Same as Above Name: _____ Date of Birth: ____/____/____ Relation: _____

Home Address: _____ Home Phone: _____

Employer/Job Title: _____ How long? _____ Work Phone: _____ ext _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name: _____ Group/Policy #: _____

Member I.D.: _____ Company Phone: _____

Insured's Name: _____ Insured's Birth Date: ____/____/____ Relation: _____

Insured's Home Address: _____ Phone: _____

Insured's SSN: ____-____-____ Insured's Employer: _____

Secondary Insurance

Insurance Co. Name: _____ Group/Policy #: _____

Member I.D.: _____ Company Phone: _____

Insured's Name: _____ Insured's Birth Date: ____/____/____ Relation: _____

Insured's Home Address: _____ Phone: _____

Insured's SSN: ____-____-____ Insured's Employer: _____

MEDICAL HISTORY INFORMATION

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Please take a few moments to inform us on your health so that we may provide the best care possible.

Name of Physician: _____ Date of last visit: _____ Phone: _____

Please check all that apply if you currently or have ever had any of the following:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Artificial Bone/Joints* | <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Angina | <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Congenital Heart Defect* | <input type="checkbox"/> Anemia | <input type="checkbox"/> Respiratory/Breathing Problems | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Tumor | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Fever Blisters |
| <input type="checkbox"/> Abnormal Heart Condition* | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> Surgical Shunt* | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> HIV* <input type="checkbox"/> AIDS* | <input type="checkbox"/> Tuberculosis TB | <input type="checkbox"/> Liver Disorder | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | <input type="checkbox"/> Kidney Dysfunction | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> STD | <input type="checkbox"/> Thyroid Problems | |

*This condition may require antibiotic premedication for certain dental procedures

YES NO

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any other health problems not listed above? Please explain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you currently under the care of a physician? Please explain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been admitted to a hospital or needed emergency care during the past 2 years? Please explain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use tobacco products? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you currently taking or have taken Alendronate Sodium (Fosomax) or other bisphosphates in the past? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you take or have you taken Phen-fen or Redux? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you take a daily aspirin regimen or any other anticoagulant/blood thinners? Please List: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you currently taking any medications or herbal supplements (including controlled substances)? Please List: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you allergic to any medications or substances? Please check all that apply: <input type="checkbox"/> Aspirin <input type="checkbox"/> Penicillin/Amoxicillin <input type="checkbox"/> Codeine <input type="checkbox"/> Latex <input type="checkbox"/> Metal <input type="checkbox"/> Sulfa Drugs <input type="checkbox"/> Local Anesthetic <input type="checkbox"/> Other: _____ |

Female Patients please check all that apply: ☐ Pregnant ☐ Trying to get pregnant ☐ Nursing
☐ Taking oral contraceptives

What is your chief concern about your dental health condition? _____

I affirm that to the best of my knowledge, all of the preceding information is correct. If I have any changes in my health status or if my medications change, I will inform the dentist and dental staff at the next appointment without fail.

Signature of Patient or Responsible Party

Date

APPOINTMENTS

Please be on time to your appointments as we have reserved a time slot for you. Please make every effort not to change your scheduled appointment. If you must reschedule, please provide at least 2 working days advanced notification so that we may use that time to accommodate other patients. Broken or missed appointments create scheduling problems for other patients and our practice. We value your time, please value ours.

FINANCIAL POLICY

Payment in full is due on the day of treatment. Any discrepancies with insurance eligibility and/or coverage will be the patient's responsibility. The insurance plan is YOURS and our office has no leverage for payments; you are ultimately responsible for all payments when service is rendered.

Payment Options

1. For your convenience we accept Cash, Check, Visa, MasterCard, Discover, and American Express.
2. We also accept Care Credit®.

For Patients with Dental Insurance

Dental insurance plans often pay less than the actual fee for service, therefore the patient or Guarantor is the responsible party for all dental services provided. We can only provide an **estimate** for treatment based on your insurance company's guidelines. Dental insurance is a benefit with limitations and should not be expected to take care of all costs. Please contact your dental insurance company for explanation.

Fees

Returned checks are subject to a \$35 accounting fee.

AUTHORIZATION AND CONSENT

General Consent to Treatment

I agree and consent to a dental examination and x-rays when needed. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information

I authorize Dr. Privett to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health professionals.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to Dr. William E. Privett D.D.S.

Photography Release

I authorize Dr. Privett to take photographs of me needed to help me better understand my current dental condition and possible treatment options. I also authorize him to provide these photographs to other dental labs for optimal quality purposes in restorative procedures.

Please list the names of anyone with whom we may discuss your dental health, treatment plans, and other matters relating to your account:

| | |
|-------------|-----------------|
| Name: _____ | Relation: _____ |
| Name: _____ | Relation: _____ |
| Name: _____ | Relation: _____ |

HIPAA PRIVACY PRACTICES CONSENT

We are required by law and regulation to protect the privacy of your medical and dental information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect. If you would like to read the HIPAA Notice in detail, a copy will be furnished upon request.

Printed Name

Signature of Patient or Responsible Party

Date