

We're happy you're here. We know filling out paperwork can be a chore, so we'll make this as easy as possible.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M  F

<b>Contact</b>	CELL	
	HOME	
	EMAIL	

<b>Address</b>			
	STREET	APT	
	CITY	STATE	ZIP

<b>Info</b>	DATE OF BIRTH		OCCUPATION		HOW DID YOU HEAR ABOUT US?	
	REASON FOR TODAY'S VISIT					

**DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?**

<b>Medical History</b>	YES	NO		
				ANEMIA
				ANXIETY DISORDERS
				ARTHRITIS
				ARTIFICIAL JOINTS (ex: hip, knee)
				ASTHMA
				BLEEDING PROBLEMS (extended bleeding)
				CANCER
				DIABETES
				DIGESTIVE PROBLEMS (ex: stomach ulcer)
				DIZZINESS or FAINTING
				EPILEPSY
				FREQUENT HEADACHES
				HEART PROBLEMS (ex: angina, heart attack, pacemaker, artificial valve, etc.)
				HIGH BLOOD PRESSURE
				IMMUNE DISORDERS
				KIDNEY PROBLEMS
				LIVER PROBLEMS (ex: cirrhosis, hepatitis)
				OSTEOPOROSIS
				SKIN PROBLEMS
			STROKE	
			THYROID PROBLEMS	
			TUBERCULOSIS or LUNG PROBLEMS	

YES	NO	
		ARE YOU PREGNANT?
		DO YOU SMOKE?
		ANY SIGNIFICANT HOSPITALIZATIONS OR SERIOUS ILLNESS?
		ANY ALLERGIES? Latex Penicillin Other:

**PLEASE LIST ALL MEDICATIONS YOU TAKE:**


I, the undersigned, hereby declare that I have read, understood, and answered the above medical questionnaire to the best of my knowledge. **I hereby promise to inform you of any change to my health.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**FOR THE DENTIST:** I acknowledge that I have read the answers to the above questionnaire and discussed with the patient.

\_\_\_\_\_  
Dentist's Signature

ASA PS:                      INITIAL BLOOD PRESSURE/PULSE:

I   II   III   IV

## Financial and Personal Information

<b>Insurance Agreement</b>	<b>IF YOU HAVE INSURANCE, PLEASE READ AND INITIAL THE FOLLOWING AGREEMENTS. OTHERWISE, SKIP THIS SECTION.</b>	
	Although we are willing to submit claims on your behalf, we do not accept responsibility for the outcome of the transaction. Completing claims is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office file your claims, it is important that you understand that this does not eliminate your financial obligation for treatment. I understand and agree to these statements.	Initial here: _____
	I understand that it's my responsibility to know the exact benefits of my plan and to manage my coverage.	Initial here: _____
	I understand that <b>my dental insurance policy is an agreement between me and the insurance company</b> . The Dentists on Rayford has no contracts in place with insurance companies. Any estimates are a true guess. <b>I agree to pay for my treatment in full regardless of what my dental insurance company pays.</b>	Initial here: _____
	The Dentists on Rayford will be happy to help estimate my insurance benefits. However, I understand that my <b>actual insurance coverage is often different than the estimated amount. I agree to pay, immediately upon notification, any balance that exists after my insurance company pays its share or if the insurance company does not pay within 60 days.</b>	Initial here: _____

<b>Share Info</b>	<b>DO YOU WANT TO US TO DISCLOSE YOUR HEALTH INFORMATION TO SOMEONE ELSE?</b>	
	By law, we cannot discuss your information with anyone besides yourself and your legal guardian. If you'd like a parent, spouse, or someone else to be able to discuss your information, write his/her information below.	
	NAME(S)	RELATIONSHIP(S) TO YOU

<b>Other</b>	<b>Who should we call in an emergency?</b> Name/Relationship _____ Phone _____	
	I understand I must confirm any future appointment via text or phone, or my appointment will be removed. I will be charged a fee up to \$150 if I miss or cancel an appointment without at least 24 hours notice.	Initial here: _____

<b>HIPAA</b>	A laminated copy of our privacy practices is behind this sheet and on our website. I have received a copy of this office's Notice of Privacy Practices. (You may refuse to sign this acknowledgement.)	
	_____ Signature	

**You're done; thank you!**