

NORTH RIDGEVILLE FAMILY DENTISTRY



Thorough ♦ Sincere ♦ Informative

Medical and Dental History

Name: _____ Date: _____

Date of Birth: _____ Social Security Number: _____ Status: M S

Address: _____

Phone Number(s): home: _____ cell: _____ work: _____

E-mail Address:

Emergency contact (name and phone):

Physician's name and phone number: _____

Employer name and phone number: _____

Dental Insurance

Do you have Dental Insurance? YES NO

If yes, are you the subscriber? YES NO

If no, please enter subscriber name: _____

Subscriber Social Security Number: _____

Subscriber Date of Birth: _____

Dental Insurance Name: _____

Insurance ID number: _____ Group Number: _____

How did you hear about us?

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Medical History

Please check if the following applies to you

- Have you had any serious illness or been hospitalized in the past 5 years?† ↑
- Are you under the care of a physician at this time?† ↑
- Are you currently taking any medications or drugs?† ↑

If yes, please list below

- Do you have or have you had any of the following diseases or problems?
- Damaged heart valves or artificial heart valves‡ ↑
- Heart Murmur or Rheumatic Heart† ↑
- Heart attack, angina, coronary insufficiency, coronary artery disease‡ ↑
- High blood pressure, arteriosclerosis, stroke‡ ↑
- Chest pain or shortness of breath after mild exertion† ↑
- Inborn heart defects‡ ↑
- Cardiac Pacemaker† ↑

Please list any drug or latex allergies

- Asthma† ↑
- Epilepsy or Seizures‡ ↑
- Recurrent Fainting or Dizziness‡ ↑
- Alcoholism† ↑
- Diabetes‡ ↑
- Hepatitis‡ ↑
- Blood test positive for AIDS or HIV
- Thyroid disease‡ ↑
- Respiratory problems‡ ↑
- Tuberculosis‡ ↑
- Arthritis or Rheumatism† ↑
- Stomach ulcer or hyperacidity† ↑
- Kidney trouble‡ ↑
- Liver disease‡ ↑
- Cancer† ↑
- Hemophilia† ↑
- Crohn's disease or IBD† ↑
- Mental health/psychiatric care‡ ↑
- History of excessive bleeding† ↑
- Are you currently pregnant?† ↑
- Have you gained or lost 10 lbs or more within the last two months?† ↑
- Have you had a joint replacement within the last two years?† ↑
- Are there any other health history concerns not already listed?† ↑

Comments

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Dental History

1. Do your gums bleed? † †
2. Do you or your spouse snore? † †
3. Have you been treated for gum disease? † †
4. Do your teeth feel sore when you bite? † †
5. Do you ever clench or grind while asleep? † †
6. Do you get frequent headaches? † †
7. Do you currently smoke or use tobacco products? † †
8. Is your mouth frequently dry? † †
9. Are your teeth sensitive to hot or cold? † †
10. Are you nervous about dental treatment? † †
11. Are you satisfied with your teeth? † †

What brings you in today? _____

The above information is accurate to the best of my knowledge. I will not hold North Ridgeville Family Dentistry responsible for any errors or omissions that I have made in the completion of this form.

Signature

Date

NORTH RIDGEVILLE FAMILY DENTISTRY



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Financial Responsibility Agreement

As a courtesy for those who have dental insurance, North Ridgeville Family Dentistry, Inc. will submit the claim to your insurance company. Due to ever changing insurance coverage, it is your responsibility to check with your insurance carrier for participation and coverage. Payment is expected at time of service. We reserve the right to withhold further treatment if there is a long outstanding balance. Twenty-four hour notice is required for all cancellations. Failure to do so will result in a \$25.00 broken appointment fee. Accounts that are sixty (60) days past due will be subject to a 5% finance charge.

I AM AWARE THAT I AM RESPONSIBLE FOR THE ENTIRE FEE FOR DENTAL SERVICES PROVIDED BY NORTH RIDGEVILLE FAMILY DENTISTRY, INC. I HAVE ALSO BEEN INFORMED THAT I AM RESPONSIBLE FOR ANY CHARGES RENDERED BY A COLLECTIONS COMPANY SHOULD MY ACCOUNT BE TURNED OVER TO COLLECTIONS.

Signature and Date: _____

Dental Insurance Authorization

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to North Ridgeville Family Dentistry, Inc.

Signature and Date: _____

Consent for Dental Treatment

I hereby agree and give my unqualified consent for any and all dental work deemed necessary by North Ridgeville Family Dentistry.

Signature and Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of this office's notice of privacy practices.

Signature and Date: _____