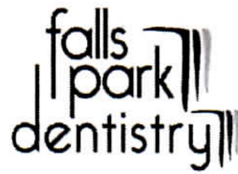

First Name:____________________ Last Name:________________________ MI:______

Preferred Name:____________________ DL #:________________________

Address: ____

City:____________________ State: _________ Zip Code: ________________

Home #: ____________________ Cell: ________________________

Birth Date: _______/_______/_______ Soc. Security: ________________________

Employer: ____________________ Work#: ________________________

Email:________________________________ ☐Check to receive emailed appt reminders

Previous Dentist: ____________________ Location/Phone #: ________________

Emergency Contact's Name: ____________________ Emergency Contact #:________________

How did you hear about us?

☐ Google ☐ Our Website ☐ Facebook ☐ Walked by ☐ Ad ____________________(please specify)

☐ Friend/ Family/ Coworker --- Who may we treat for referring you to us?________________

Receipt of Privacy Practice and Financial Policy

I have read and have access to the notice of HIPAA Privacy Practices and Financial Policy used by Falls Park Dentistry. ☐ YES ☐ NO

I authorize the release of my medical information to my insurance company should it be required for payment of my claim. ☐ YES ☐ NO

Falls Park Dentistry will leave a general message prior to appointments. I authorize detailed messages and/or conversations regarding my treatment, clinical concerns, etc to the following individuals:

Name____________________ Relationship________________ Phone____________

Falls Park Dentistry uses a software to send appointment reminders via text and email. I understand I can edit my preferences directly to opt out of text or email reminders.

I authorize Falls Park Dentistry to send annual appointment reminders via Postcard. ☐ YES ☐ NO

I UNDERSTAND THAT THESE AUTHORIZATIONS ARE IN EFFECT UNTIL REVOKED BY ME IN WRITING

Date________________ Signature ________________________________

Patient Name: ______________________ Date Created: ______________________

Are you under a physician's Care now? ☐ YES ☐ NO Who is your provider?__________

Have you ever been hospitalized or had a major operation? ☐ YES ☐ NO If yes__________

Have you ever had a serious head or neck injury ☐ YES ☐ NO If yes__________

Are you taking any medications? ☐ YES ☐ NO If yes__________

Do you take or have you taken, Phen-Fen or Redux? ☐ YES ☐ NO If yes__________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ YES ☐ NO If yes__________

Are you on a special diet? ☐ YES ☐ NO

Do you use tobacco? ☐ YES ☐ NO

WOMEN: Are you......

☐ Pregnant? ☐ Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you ALLERGIC to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

☐ Other __________

Do you use controlled substances? ☐ Yes If Yes __________

Do you have, or have you had, any of the following:

AIDs/ HIV	☐ YES	Cortisone Medicine	☐ YES	Hemophilia	☐ YES	Radiation Treatments	☐ YES
Alzheimer's Disease	☐ YES	Diabetes	☐ YES	Hepatitis A	☐ YES	Recent Weight Loss	☐ YES
Anaphylaxis	☐ YES	Drug Addiction	☐ YES	Hepatitis B or C	☐ YES	Renal Dialysis	☐ YES
Anemia	☐ YES	Easily Winded	☐ YES	Herpes	☐ YES	Rheumatic Fever	☐ YES
Angina	☐ YES	Emphysema	☐ YES	High Blood Pressure	☐ YES	Rheumatism	☐ YES
Arthritis/ GOUT	☐ YES	Epilepsy/ Seizures	☐ YES	High Cholesterol	☐ YES	Scarlet Fever	☐ YES
Artificial Heart Valve	☐ YES	Excessive Bleeding	☐ YES	Hives or Rash	☐ YES	Shingles	☐ YES
Artificial Joint	☐ Yes	Excessive Thirst	☐ Yes	Hypoglycemia	☐ Yes	Sickle Cell Disease	☐ Yes
Asthma	☐ YES	Fainting Spells/ Dizziness	☐ YES	Irregular Heartbeat	☐ YES	Sinus Trouble	☐ YES
Blood Disease	☐ YES	Frequent Cough	☐ YES	Kidney Problems	☐ YES	Spina Bifida	☐ YES
Blood Transfusion	☐ YES	Frequent Diarrhea	☐ YES	Leukemia	☐ YES	Stomach/ Intestinal Disease	☐ YES
Breathing Problems	☐ YES	Frequent Headache	☐ YES	Liver Disease	☐ YES	Stroke	☐ YES
Bruise Easily	☐ YES	Genital Herpes	☐ YES	Low Blood Pressure	☐ YES	Swelling of Limbs	☐ YES
Cancer	☐ YES	Glaucoma	☐ YES	Lung Disease	☐ YES	Thyroid Disease	☐ YES
Chemotherapy	☐ YES	Hay Fever	☐ YES	Mitral Valve Prolapse	☐ YES	Tonsilitis	☐ YES
Chest Pains	☐ YES	Heart Attack/ Failure	☐ YES	Osteoporosis	☐ YES	Tuberculosis	☐ YES
Cold Sores/ Fever Blisters	☐ YES	Heart Murmur	☐ YES	Pain in Jaw Joints	☐ YES	Tumors or Growths	☐ YES
Congenital Heart Disorder	☐ YES	Heart Pacemaker	☐ YES	Parathyroid Disease	☐ YES	Ulcers	☐ YES
Convulsions	☐ YES	Heart Trouble/ Disease	☐ YES	Psychiatric Care	☐ YES	Venereal Disease	☐ YES
Serious Illness Not Listed:						Yellow Jaundice	☐ YES

To the Best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: ______________________ Date: __________

Office Policy

Thank you for choosing Falls Park Dentistry as your dental home. We look forward to taking excellent care of your oral health.

Insurance: We accept and file **primary** dental benefit plans. We cannot assume responsibility of your payment by your insurance carrier, nor can we accept their payment as payment in full. Generally, most plans pay a percentage of covered procedures up to a set annual maximum. As a courtesy, we will provide you with an expected insurance payment. **I understand that my insurance is a contractual agreement between myself and my insurance company. I agree to pay any amount not paid by my insurance company.**

Patient Signature

X ____________________

Financing: Falls Park Dentistry provides a **6 month** no interest payment plan through **Care Credit**. Please ask one of our front team members about how to apply.

Compliance Updates: You will be legally required to update a HIPPA form and Medical History form **once a year**. You will also be required to update radiographs a **minimum of every two years** in order to stay a patient of record and for accurate diagnostic purposes.

Patient Signature

X ____________________

Appointment Protocol: Your scheduled appointment is a priority to us. If you must cancel your appointment and do not provide at least **48 hour** notice you will not be given priority re-appointment. If an appointment is failed more than 3 times in a year you will be required to prepay for services. Our team looks forward to your scheduled visit we ask that you please be courteous to your provider's valuable time and attention. If you are more than **15 minutes** late your appointment will be rescheduled.

Patient Signature

X ____________________

Accepted Payment: We accept Visa, Mastercard, Discover, American Express, debit cards, and cash. **We do not accept personal checks at time of service.**

Payment for all deductibles, non-covered services and patient portions are due the day services are rendered.

***Please confirm current address and phone number-

____

Receipt of Privacy Practice Information

Patient Name: ____

I have read and have access to the notice of privacy and acknowledgement used by Falls Park Dentistry.

YES NO

I authorize the release of my medical information to my insurance company should it be required for payment of my claim.

YES NO

Falls Park Dentistry will leave a general message prior to appointments.

I authorize detailed messages and/or conversations regarding my treatment, clinical concerns, etc to the following individuals:

YES NO

Name________________________ Relationship____________________ Phone_______________

Name________________________ Relationship____________________ Phone_______________

Name________________________ Relationship____________________ Phone_______________

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I authorize Falls Park Dentistry to send annual appointment reminders via Postcard.

YES NO

I UNDERSTAND THAT THESE AUTHORIZATIONS ARE IN EFFECT UNTIL REVOKED BY ME IN WRITING

Date___________ Signature ____