PATIENT INFORMATION

NAME (Last,First,Middle)_____Title:_____

HOME ADDRESS:_____DOB:__/_____/_____

CITY & ZIP:_____SSN:_____-_____-_____

HOME PHONE:_____CELL PHONE:_____

WORK PHONE:_____E-MAIL:_____

MARITAL STATUS: Single Married Divorced Widowed SEX: Male Female

DRIVER'S License:_____STATE:_____

SPOUSAL INFORMATION

NAME:_____DOB:_____

EMPLOYER:_____EMPLOYER ADDRESS:_____

SSN:__/_____/_____ DRIVER'S LICENSE #:_____ STATE:_____

PHONE/CELL:_____

EMPLOYER INFORMATION

EMPLOYER:_____WORK PHONE:_____

EMPLOYER ADDRESS:_____

IF PATIENT IS A MINOR

FATHER'S NAME:_____DOB:___/_____/_____SSN:____-_____-____

ADDRESS:_____HOME PHONE:_____

EMPLOYER:_____WORK PHONE:_____EXT___

MOTHER'S NAME:_____DOB:___/_____/_____SSN:____-_____-____

ADDRESS:_____HOME PHONE:_____

EMPLOYER:_____WORK PHONE:_____EXT___

PERSON FINANCIALLY RESPONSIBLE:_____

DRIVER'S LICENSE #:_____STATE:_____SSN:____-_____-_____

HEALTH HISTORY

What type of dental problem brought you to our office today?_____

Physician:_____Last physical exam:_____/_____/_____

Are you in good health? YES / NO If no, please explain:_____

_____

Are you now or have you recently been under a physician's care? YES / NO

Reason:_____

Do you bleed excessively when cut? YES / NO Do you smoke: YES / NO

Medical alerts:_____

Have you ever been told you have periodontal disease? YES / NO

Please circle each of the following you have had or suspected:

Aids	Y / N	Liver Disease	Y / N	**Have you ever had or**	
Anemia	Y / N	Low Blood Pressure	Y / N	**been diagnosed with:**	
Arthritis, Rheumatism	Y / N	Nervous Problems	Y / N	Artificial Heart Valve	Y/ N
Asthma	Y / N	Psychiatric Care	Y / N	Artificial Joints,Screws	Y/ N
Back Problems	Y / N	Radiation Treatment	Y / N	Pins,etc.	
Cancer	Y / N	Respiratory Disease	Y / N	Bleeding abnormally,	Y/ N
Chemical Dependency	Y / N	Scarlet Fever	Y / N	with extraction/surgery	
Chemotherapy	Y / N	Shortness of Breath	Y / N	Blood Disease	Y/ N
Circulatory Problems	Y / N	Sinus Trouble	Y / N	Congenital Heart	Y/ N
Cortisone Treatments	Y / N	Skin Rash	Y / N	Lesions	Y/ N
Cough, constant/bloody	Y / N	Special Diet/Weight Loss	Y / N	Heart Murmur	Y/ N
Diabetes	Y / N	Stroke	Y / N	Heart Repair	Y/ N
Emphysema	Y / N	Swollen Feet/Ankles	Y / N	Mitral Valve Prolapse	Y/ N
Epilepsy	Y / N	Swollen Neck Glands	Y / N	Pacemaker	Y/ N
Fainting or dizziness	Y / N	Thyroid Problem	Y / N	Rheumatic Fever	Y/ N
Glaucoma	Y / N	Tonsillitis	Y / N		
Headaches	Y / N	Tuberculosis	Y / N	**Are you allergic to:**	
Heart Problems	Y / N	Tumor or Growths	Y / N	Aspirin	Y / N
Hepatitis Type_____	Y / N	Ulcer	Y / N	Barbiturates	Y / N

Herpes	Y / N	Venereal Disease	Y / N	Codeine	Y / N
High Blood Pressure	Y / N			Ibuprofen	Y / N
HIV Positive	Y / N			Latex	Y / N
Jaundice	Y / N			Local Anesthesia	Y / N
Jaw Pain	Y / N			Metals (i.e. gold)	Y / N
Kidney Disease	Y / N			Penicillin	Y / N

Please list any current medications: _____

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name:_____Phone:_____

Address:_____

WOMEN ONLY:

Are you pregnant Y / N If yes, how many months?_____

Are you breastfeeding? Y / N

Are you taking any birth control medications? Y / N

I consent to the dental procedures and anesthetics necessary for treatment described and agreed to. I accept full responsibility for all treatment rendered.

_____ _____ _____

Signature (patient or responsible party) Print Date

This practice is aware of the unfortunate reality of Medical Identity Theft in our society. Our procedures will reflect the current standards required by the Federal Trade Commission in verifying your identity. If your identification has been stolen, please do advise us so we can prevent any possible compromise to your identity.

Our purpose is to have you leaving here with a smile.

Financial Policy

To our Valued Patient,

In order to keep our fees from rising and keep up with the monumental expenses of bookkeeping and billing services, we have opted to offer our patients new payment policies. This will help reduce our overhead, thus passing the savings along to our patients by being able to maintain our current fee schedule.

1. In order to keep billing to a minimum,, we ask that payment for services be made at the time of visit, unless previous financial arrangements have been made. The entire cost is incurred on the first visit for services requiring lab work, such as: crowns, bridges, dentures, partials, occlusal guards etc., and must be paid in full before cementation. Payments may be made by cash, check, and credit card or through our financial company for easy monthly payments (credit approval is required).

2. Custom made items such as crowns, bridges, partials, etc., take more than one appointment. In the event a patient does not come in for completion of their treatment **payment in full is still due**.

3. Patients having dental insurance will be asked to pay their deductible and estimated portion of the fee at the time services are rendered and will also be responsible for any balance remaining after the insurance company has paid the claim.

4. While the filing of insurance claims is a courtesy that we extend to our patients, we must emphasize that as dental providers, our relationship is with the patient, not the insurance company.

I authorize the release of any information relating to my dental care. I understand that I am responsible for all costs of dental treatment. I hereby authorize payment directly to the above named dentist of the group insurance benefits otherwise payable to me.

I agree to pay all cost of collections for any outstanding amounts to my account including a reasonable attorney fee. I understand this may increase my outstanding charges by 33 1/3 %_____ please initial.

I have read the above financial policies and agree to abide by them.

_____ _____ _____

Signature of Patient or responsible party Print Date

NOTICE OF PRIVACY PRACTICES

As a patient you have the right to:

1. Tell us the preferred way to contact you to ensure your privacy.
2. Ask us to limit the ways we use your information.
3. Find out: How your information will be used
4. Files a complaint if you feel your privacy rights have been violated.
5. View your medical records and get copies if needed.
6. Request changes to your records.
7. Decide not be included in our patient directory
8. Decide whether we can send information about products and services to you.

I have read and understand my rights of the HIPAA compliance Record offered by this office.

I authorize the office staff to discuss any and all procedures relating to my dental services with my insurance company and referring doctors.

_____ _____ _____

Signature (patient or responsible party) Print Date

How did you hear about our practice?_____

_____

Vaughn Family Dentistry

Dear Valued Patient:

We have prepared this letter help you understand the complexities of dental insurance, realizing how confusing it can be. To begin, we would like to highlight a misconception that dental insurance was not designed to pay for all dental care. Most contractors have limits and/or various degrees of co-payment.

All levels of payment by insurance companies, including allowed fees, usual and customary (UCR), are governed by premiums paid. They have nothing to do with the actual charges. Our fees are based upon a combination of our cost, our time, and our constant dedication to supplying our patients with the highest quality of dental care. The treatment recommended by our office is never based on what your insurance company will pay; your treatment should not be governed by your insurance contract.

However, it should be understood that the dental insurance contract is between the insurance company and the patient, whom bears the ultimate financial responsibility.

We hope this information has been helpful. Please take the time to review your contract thoroughly so we may best serve you. As always, you may feel free to ask any member of our staff for help on services, billing and insurance.

Sincerely,

Vaughn Family Dentistry

Dental Insurance Information

Print Full Name:_____ Date:_____

Primary Insurance

Dental Insurance Co: _____Contract #_____

Whose Name Is Insurance In:_____

Employer:_____

Employer Address:_____

Phone:_____

Secondary Insurance

Dental Insurance Co:_____Contract #_____

Whose Name is Insurance In:_____

Employer:_____

Employer Address:_____

Phone:_____