# FOREVER DENTAL

**Patient Information**

Name: _____ Preferred Name: _____

Patients Social Security #: _____ Patients Birth Date: _____

If minor, name of legal guardian: _____ Birth Date of legal guardian: _____

Check all that apply:

| | | | |
|---|---|---|---|
| ☐ Single | ☐ Divorced | ☐ Minor | ☐ Male |
| ☐ Married | ☐ Widowed | ☐ Student | ☐ Female |

Address: _____
Street City Zip Code

Cell Phone: _____ Addt'l. Phone: _____ Work: _____

Email: _____

- *I understand Forever Dental will contact me through the following,*

Text Message, Cell Phone, Mail, and E-mail

Emergency Contact

Name: _____ Phone number: _____

Relation to patient: _____

Primary Insured/Responsible Party or ☐ Not covered by dental insurance

Name: _____ Birth date: _____
Cell Phone: _____ Relationship to patient: _____
Employer Name: _____
Dental Insurance Company: _____
SS# or ID #:_____Group #:_____

Has any member of your family ever been treated in our office? ☐ Yes ☐ No

How did you hear about our office? (Please circle one)

Friend/family (name) _____ Insurance (which insurance?):_____

Google Yelp Facebook Other: _____

I hereby authorize payment directly to Forever Dental of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Forever Dental to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information in this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my medical/dental histories and other information about my dental treatment to third party payers and/or other health professionals.

_____

Signature of Patient or Responsible Party Date

**Confidential Health History Form**

FOREVER **DENTAL**

**Patient Name**: _____ **Birth Date**: _____ **Male**: ☐ **Female**: ☐

1. Have you been under the care of a physician recently or within the last two years? ☐ Yes ☐ No

If yes please explain: _____

2. Have you had any serious illness, surgery or been hospitalized? ☐ Yes ☐ No

If yes please explain: _____

3. Are you disabled? ☐ Yes ☐ No

If yes please explain: _____

4. Do you use tobacco products or smoke? ☐ Yes ☐ No

5. Do you take any recreational/illicit drugs? ☐Yes ☐ No How often? What do you take? _____

***Has your physician ever told you to take antibiotics prior to a dental appointment?*** ☐ ***Yes*** ☐ ***No***

## Do you have or have you had any of the following? (Please check all that apply)

☐ Blood Problems (Anemia)
☐ Abnormal bleeding
(Heavy Bleeding)
☐ Blood Transfusion
☐ Heart Condition:
_____
☐ Heart murmur, heart defect
☐ Heart pacemaker
☐ Stroke
☐ Bone or joint problems
☐ Artificial joint or valves
☐ **High** or **low blood** pressure (Circle one)
☐ Tuberculosis or other lung problems

☐ Kidney disease
☐ Hepatitis, Treatment:
_____
☐ Liver Disease, Jaundice
☐ Diabetes
☐ Seizures
☐ Thyroid problems
☐ Arthritis
☐ Herpes or cold sores
☐ AIDS or HIV positive
☐ Cancer Type:
_____DATE_____
☐ Tumors
☐ Chemotherapy

☐ Radiation Therapy
☐ Endocarditis
☐ Psychiatric Care
☐ Organ Transplant
☐ Drug dependence
☐ Depression
☐ Asthma
☐ Autism
☐ ADHD
☐ Other:
_____

**Are you allergic to, or have you reacted adversely to any of the following?**

☐ Latex
☐ Penicillin or other antibiotics
☐ Codeine or other Narcotics
☐ Aspirin
☐ Other
☐ None

**Are you taking any of the following?**

Taking Contraceptives ☐ Yes ☐ No Taking Hormones ☐ Yes ☐ No

**Women:** Are you pregnant or plan to become pregnant: ☐ Yes- Due Date _____ ☐ No

List of medications currently taking: _____
_____
_____

**I have reviewed my health history and confirm that it accurately states past and present conditions.**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize my dentist to contact my physician.**Family Physician's Name**: _____ **Physicians Phone Number**: _____I understand that the above information is necessary to provide dental care in a safe and efficient manner. The above information is accurate and complete to the best of my knowledge. I will not hold Forever Dental, the dentist or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

**Patient Signature/ Guardian Signature** **Date**

## Patient Financial Responsibility Notice/Notice of Privacy Practices

## Financial Policy

**Please initial below**

_____ **Insurance & Coinsurance:** If you have insurance coverage, we will make our best efforts to coordinate your care in a cost-effective manner within the limits of your insurance benefit and to minimize the expenses for which you are responsible for. Your policy determines the extent to which you will be responsible for all deductibles, co-payments, co-insurance, and non-covered services. FD is not responsible for incorrect information given by your insurance company or failure of your employer to provide accurate information to your insurer about your employment status. The coverage available to you depends upon your employment status and the choices you make within the plans that are offered to you buy your employer. We rely on you to keep FD up to date with correct information about your coverage. This information includes, but is not limited to:

- Change of your employment status or status as a beneficiary under family coverage
- Change of insurance company or plan offered by your employer
- Loss of insurance coverage or bankruptcy of your employer

_____ **Insurance Copayments, Deductibles:** You are financially responsible for all charges incurred for treatment unless we can verify insurance benefits and expect to receive payment from a valid insurance plan. Patients that have dual dental coverage will still be responsible for any non-covered services by either primary or secondary insurance. Each insurance may have its own deductible and must be met individually by the patient.

_____ **Fees, Scheduling, and Collection:** FD may find it necessary to decline to treat any patient if the insurer or patient has not made payment. There is a charge of $25 for NSF checks along with the amount for the check. We make every effort through text messages, email and voice message to confirm and remind you of your appointment. We reserve the right to charge $35 for cancellations of less than 48 hours, multiple reschedules and no shows. Excessive abuse of re-scheduled and/or canceling appointments may result in discharge from the practice. All costs incurred for the collection of past due accounts, including reasonable attorney's fees will be passed onto you.

_____ **Minors:** Minors must be accompanied by a parent or a guardian to be seen in the office, unless special arrangements have been made with the office.

**Notice of Privacy Practices/HIPAA**

The Health Insurance Portability and Accountability Act of 1996 requires that health care providers give patients a copy of the office Notice of Privacy Practices and make a good faith effort to obtain an acknowledgement of receipt of same. You may refuse to sign this acknowledgement form.

Please be advised that we do communicate with our patients by text messages, voice mail, e-mail and postcards. Please let us know if you would like to place any restrictions on this.

**Is there anyone you would allow us to share your dental/medical information with?**

Please circle one: **Yes/No** **Name of person:** _____

Provide the date of birth of person: _____ (Relationship) _____

_____I have read and understand the above policies, and I agree to accept full financial responsibility as described. I authorize payment to FD of insurance benefits for claims submitted on my behalf. I authorize FD to release any dental/medical information necessary for claims payment.

_____ I have been offered a copy of the office Notice of Privacy Practices.

**Patient signature (Guardian):** _____**Date:** _____

**Print Name(s):** _____