FOREVER DENTAL

Patient Information

Name: _____I prefer to be called: _____

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 Authorize Forever Dental to contact me through the following :*

☐ cell phone	☐ mail
☐ email	☐ text message (SMS)

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 learn 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 payors and/or other health professionals.

Signature of Patient or Responsible Party **Date**

Confidential Health History Form

FOREVER DENTAL

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

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 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 Problems
☐ 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: _____
☐ 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 ☐ Codeine or other narcotics ☐ Other: _____
☐ Penicillin or other antibiotics ☐ Aspirin

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.

Date	Changes	Patient Initials	Doctors Initials

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** **D.D. S.**

Patient Financial Responsibility Notice/Notice of Privacy Practices

Financial Policy
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.

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. 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

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.

Schedule Policy

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 24 hours and no shows**.

Excessive abuse of re-scheduled and/or canceling appointments may result in discharge from the practice.

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: _____

For security purposes, please provide the date of birth of person: _____

☐ 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 confirm that I have received a copy of the office Notice of Privacy Practices.

Patient signature: _____Date: _____

Printed name: _____