FOLEY FAMILY DENTISTRY, PC DATE:

PATIENT INFORMATION

Full Name:_________________________________ Name commonly used: ________________________

Date of birth: ________________________________ Sex: (circle one) Female Male

RESPONSIBLE PARTY INFORMATION

Social Security # _____________________________ Driver's License # _______________________

Mailing Address:_____________________________ 911 Address:___________________________________

____ ____

Employer:___________________________________ Email address: _________________________________

(Please ☑ check the best number to call) Do you receive text messages? ____________
Home Phone:________________ Work Phone: ________________ Cell Phone:__________________

If child (under age 21), name of parents: ____
In case of divorce, with whom does the child live? ____

If married, name of spouse: _____________________ Phone Numbers ______________,________________

Referred by: _________________________________

In case of an emergency, whom may we contact? _______________________, Phone #____________________

What is the relationship of the contact to the patient? __________________________

INSURANCE INFORMATION

	Plan 1	Plan 2
Name of Policyholder:		
Birth Date of Policyholder:		
Social Security # of Policyholder:		
Employer:		
Member/ ID Number:		
Group #:		
Insurance Company:		

In case of a divorce: If there are two insurance plans, which plan does the divorce decree list as the primary carrier for the children? _______________________________

(OVER)

FINANCIAL AGREEMENT

Option 1: **For those who do have dental insurance.** **If not skip to Option 2**

I acknowledge that it is my responsibility to have read and understand my insurance policy. This includes being aware of policy limitations, exclusions, waiting periods, deductibles and maximum annual benefits.

I understand that my insurance may only pay a percentage of the total fee and that I will be responsible for the balance not covered by insurance.

I acknowledge that it is my responsibility to keep up with my yearly maximum allowance and agree to pay all fees incurred beyond that annual maximum benefits allowance.

Signed:_______________________________________

TERMS OF PAYMENT

Paying deductibles and co-pays

1. Deductibles are to be paid the first visit of the contract's new year. Most policies renew in January. It is common that policies have a three person in a family per year deductible clause. Please verify this in your plan.
2. Co-pay (the amount not covered by insurance) is to be paid at each visit.
3. The balance of unpaid fees, denied by insurance due to limitations, exclusions or reached maximums, is to be paid in full within 60 days of the insurance claim submission.

I have read the above terms of payment and agree. If I default on my account, I agree to pay all costs of collecting the indebtedness, including court costs and a reasonable attorney's fee. I further waive exemption of any personal property in the collection of debt.

Signed: ____ Date: _______________________

Relationship to patient? _________________

Options 2: **For those who do not have dental insurance –please read and sign below.**

I acknowledge full responsibility for all costs incurred for dental services and will pay for those services at each visit. Should I default on my account, I agree to pay all costs of collecting the indebtedness including court costs and a reasonable attorney's fee. I further waive exemption of any personal property in the collection of this debt.

Signed:____ Relationship to patient? __________________________

DENTAL HEALTH INFORMATION

1. How long has it been since you have had regular dental care, such as cleaning, films, exam? ______________________________________
2. Do you have pain in your mouth?_________ If so, where? ____
3. Do your gums bleed? ________
4. Do you desire to restore your teeth? _________ Date:_____________

MEDICAL HEALTH INFORMATION

Patient's Name:___________________________________ Date: ___________________

Physician's Name: _________________________________ Pharmacy __________________ Located __________

Do you currently have or have you ever had….

	(Circle One)			(Circle One)	
1. Major surgery	Yes	No	10. Diabetes	Yes	No
Type of surgery? _____________________			Type of diabetes? __________		
2. Serious injury to teeth or jaw?	Yes	No	11. Anemia	Yes	No
3. Heart disease	Yes	No	13. Venereal Disease	Yes	No
Type:_______________________________					
4. High Blood Pressure	Yes	No	14. Hepatitis	Yes	No
Medication?:_________________________			Type:__________When? ______________		
5. Abnormal bleeding	Yes	No	15. Rheumatic Fever	Yes	No
6. Fainting Spells	Yes	No	16. Tested Positive HIV/AIDS	Yes	No
7. Shortness of Breath	Yes	No	17. Tuberculosis	Yes	No
8. Allergies to medications	Yes	No	18. Are you required to pre-medicate?____		
9. If yes, what are you allergic to?			19. Please list all medications you are taking:		

_________________ __________________ _________________ _________________
_________________ __________________ _________________ _________________
_________________ __________________ _________________ _________________

Medical Updates: (office use only)

_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________

HEALTH INFORMATION RELEASE CONSENT

The staff of Foley Family Dentistry, PC has been trained to protect the privacy of your medical health information. Should you have dental insurance, it may be necessary to release dental and /or health information for the payment of dental claims. This office is in compliance with the 1996 HIPAA act and will make every effort to assure your rights to privacy are honored.

(OVER)

(Insured patients only) I give my consent to Foley Family Dentistry, PC to release any requested health information to my insurance company to process my insurance claims. I understand the HIPAA act of 1996 allows insurance companies to request such information and my dentist to provide that information with my consent. I further consent to Foley Family Dentistry, PC filing my dental claims on my behalf.

Signed: ____ Date:__________________

(All patients) I give my consent to Foley Family Dentistry, PC to release any requested health information deemed necessary for dental treatment by any dentist I may be referred to by Foley Family Dentistry, PC. I understand I have the right to restrict information and to revoke consent except on procedures in process or completed.

Signed: ____ Date: __________________

PARENTAL CONSENT FOR MINORS

I, ____, parent or legal guardian of _________________________ do affirm with my signature:

1. That my child or legal ward may receive routine dental care at Foley Family Dentistry, PC.
2. That I or those listed below are the only persons permitted to accompany my child to Foley Family Dentistry, PC for dental care: ______________________________, ________________________________
3. That once my child reaches the age to drive, he or she may come into the office for care without me or agreed upon persons being present. However, I understand that in the case of emergency care, I or an agreed upon person, must accompany my child to make decisions about care.
4. That my child's health information, as related to dental care, may be released to my insurance company (if applicable) for the purpose of insurance claims payments. This includes permission to file claims.
5. That dental and medical health information may be shared with another dentist should my child or ward transfer to another dentist or be referred for treatment to another dentist.

Signed: ____ Date: _______________

Relationship to patient: ____________

PLEASE PRESENT THE RECEPTIONIST:

YOUR INSURANCE CARD AND DRIVER'S LICENSE FOR COPYING.

THANK YOU.