Patient Health Record Update

In order to help me render the proper dental services to you, would you please be kind enough to answer the following questions about your medical and dental health. Please note the space for remarks for any answers that require clarification or any other information you think I should have. Thank you for your cooperation.

Date:_____

Patient Name:_____
(Last) (First) (Middle Initial) (Name you wish to go by

Address:_____
(Address) (City / State / Zip)

Patient's Date of Birth:_____ Home Phone:_____

Patient's SS#:_____-_____-_____ Cell Phone:_____

Patient's Occupation:_____ Work Phone:_____

Employer & Address:_____

Martial Status: Single_____ Married_____ Widowed _____ Divorced _____

Spouse Name:_____Spouse Employment:_____

In case of Emergency, Whom should we notify?_____
(Name & Relationship) (Phone #)

Most convenient Appointment time:_____ Email address:_____
(email for patient contact purposes only)

MEDICAL HISTORY

General Health: Excellent_____ Good_____ Fair_____ Poor_____

Name of Physician:_____ Last date complete physical:_____

Are you under physical care other than routine visits? Yes_____ No_____

If yes, for what purpose?_____

Are you taking any medication at this time? Yes_____ No_____

If yes, please list:_____

HAVE YOU EVER BEEN TREATED FOR: *(please circle)*

Heart Disease	Yes	No	Heart Murmur	Yes	No
Rheumatic Fever	Yes	No	Asthma Hay Fever	Yes	No
Abnormal Blood Pressure	Yes	No	Sinus Trouble	Yes	No
Arthritis	Yes	No	Latex allergy	Yes	No
Hepatitis	Yes	No	Active Tuberculosis or Lung Disease	Yes	No
Diabetes	Yes	No	Artificial joint replacement	Yes	No
Epilepsy	Yes	No	Sexually transmitted Diseases	Yes	No
Stroke	Yes	No	HIV / AIDS Infection	Yes	No
Thyroid Condition	Yes	No	Drug or Alcohol Therapy	Yes	No

Do you have any known allergies to Medications such as Penicillin, Codeine, Novocaine, Other?_____

Are you subject to prolonged bleeding?_____ Fainting Spells?_____

Do you Smoke or use any other Tobacco product?_____ How much per day?_____

(WOMEN)Are you taking Birth Control Pills?_____ Are you now Pregnant?_____ How far along?_____

Patient SignatureX_____
(Parent Signature if patient is a minor)

(OVER PLEASE) >>>

Financial Policy

In order to minimize costs associated with billing and the costs of our dental services to you in advance, payment is expected at the time services are rendered unless prior financial arraignments have been made. For your convenience, we gladly accept *Cash* or *Check*, as well as *Visa*, *MasterCard*, and *Discover*. Our office also accepts CareCredit®. For more information about our payment options please ask the front office staff!

For our patients who are covered by DENTAL INSURANCE, as a courtesy, we are happy to assist in filing your insurance. We file *primary insurance only*, you will be responsible for filling any secondary coverage(s) you might have. We ask that you pay for your estimated co-payment (the amount insurance does not pay) at each appointment Since the insurance agreement is between you and your insurance company, we do not assume responsibility if, for any reason, they deny payment for treatment. If, after 75 days your insurance company has not met their obligation on your behalf, you will be responsible for total payment. Of course, should any problems arise we will be more than happy to provide your insurance company with any additional information that is necessary.

I have read the financial policies of Dr. Dale R. Dunn's office and understand them in full. I agree to the above stated policies. I understand that Dr. Dunn offers a courtesy service by accepting assignment from my insurance company and by filing my insurance for me and/or my family. I understand that ultimately the financial responsibility for dental services provided in this office for my self and/or my family is mine. I further understand that a 1.5% finance charge may be added to past due balance after 60 days. In the event of default, I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Please sign below that you have read and fully understand the above policy:

X_____ Date:_____

(Financially Responsible Parties Signature)

Financially Parties Relationship to Patient: _____

IF PATIENT IS A STUDENT, PLEASE COMPLETE:

School Attending:_____ Full Time or Part Time

IF PATIENT IS A CHILD, PLEASE GIVE COMPLETE NAMES OF BOTH PARENTS:

Mother:_____ Father:_____

PATIENTS COVERED BY DENTAL INSURANCE PLEASE COMPLETE THE FOLLOWING:

Patient's Name:_____ Date of Birth:_____

Patient's Relationship to Insured: Self_____ Spouse_____ Child_____ Other_____

Insured's Name: _____

Insured SS#: _____ Date of Birth:_____

Insured's Employer:_____

Name of Insurance Company:_____

Insurance Address:_____

Insurance ID#: _____ Group Policy #:_____

Insurance Phone #: (_____) _____

ASSIGNMENT OF BENEFITS FOR DENTAL INSURANCE:

I authorize the release of any information relating to my dental treatment to the dental insurance company claims.
In addition, I hereby authorize my insurance company to pay directly to Dale R. Dunn, D.D.S., for all dental services performed.

Signed:X_____ Date:_____

(Responsible Party or Patient)