Contemporary Family Dentistry
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PATIENT INFORMATION

About You …

Name (First) _____ (MI) ____ (Last) _____

Preferred Name: _____

SSN: _____Birth Date:_____

Gender (M /F) Marital Status:_____

Home Address_____

City _____ State _____ Zip _____

Parents name(s) if patient is a minor_____

Employer _____

Primary Insurance: _____

Policy Holder Name: _____

SSN _____ DOB: _____

ID# _____ Group# _____

Secondary Insurance: _____

Policy Holder Name: _____

SSN_____ DOB: _____

ID#:_____ Group#_____

Contact Information

CELL_____

HOME_____

WORK _____

E-mail_____

Spouse Information

Spouse Name: _____

Phone: _____

Emergency Contact

Name_____

Phone Number_____

Relationship_____

Do you have a Doctor preference?

Dr. Johnson Dr. Mills Dr. Evetts

How did you hear about us? _____

Other family members seen by us? _____

Broken Appointment Policy

A minimum of 24 hours' notice for appointments that need to be rescheduled or canceled is required. A $30 fee may be charged for same day cancellations and missed appointments. **Patient or Guardian Initials**: _____

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Contemporary Family Dentistry and/or the treating dentist(s) all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr.Johnson, Dr. Mills and Dr. Evetts may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits.

Signature of Patient, Parent, Guardian or Personal Representative _____

Print above signed name _____Relationship to Patient _____ Date _____

Dental History

Reason for today's visit _____Former Dentist _____

Date of last dental visit _____Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had the following.

Bad Breath ___ yes ___ no	Bleeding gums ___ yes ___ no	Blisters on lips or mouth ___ yes ___ no
Dry mouth ___ yes ___ no	Grinding Teeth ___ yes ___ no	Burning sensation on tongue ___ yes ___ no
Jaw pain ___ yes ___ no	Sensitive to hot ___ yes ___ no	Sensitive to cold ___ yes ___ no

Do you smoke or use smokeless tobacco?_____ How long? _____ Have you quit? _____ How long ago?_____
How often do you brush? _____How often do you floss?_____

Health History

Who is your primary care physician?_____

Do you drink alcohol? ___ yes ___no How often? _____ Has your drinking ever caused you problems? ___ yes ___ no
Have you ever used recreational drugs? ___ yes ___ no Do you currently use drugs? ___ yes ___ no
Have you ever had a serious illness or surgery? _____ What and When? _____
Have you ever had a blood transfusion? _____ When? _____
Do you snore? ___yes ___no Do you use a CPAP at night? ___yes ___no

Place a mark to indicate if you have had any of the following:

___Anemia
___Angina Pectoris
___Arthritis
___Artificial Heart Valve
___Artificial Joints
___Asthma
___Cancer - chemo
___Congenital Heart Defect
___Diabetes
___Difficulty Breathing
___Emphysema
___Epilepsy
___Fever Blisters
___Frequent Headaches
___Glaucoma
___HIV/AIDS
___Heart Attack
___Heart Murmur
___Heart Surgery
___Hemophilia
___Hepatitis A
___Hepatitis B
___Hepatitis C
___High Blood Pressure
___Kidney Problems
___Liver Disease
___Mitral Valve Prolapse
___Pace Maker
___Psychiatric Problems
___Radiation Therapy
___Rheumatic Fever
___Seizures
___Smokeless Tobacco
___Smoker
___Stroke
___Thyroid Problems
___Tuberculosis
___Ulcers
___Blood Thinners

Women: Are you pregnant?_____ How many weeks?_____
Are you nursing?_____
Do you take birth control?_____

* Do you take a PREMED before dental appointments? _____

List all Medications you are taking

_____
_____
_____
_____
_____
_____
Pharmacy Name_____
_____
Pharmacy Phone_____

Allergies

Aspirin___ Dental Anesthetics____
Penicillin___ Erythromycin___
Codeine___ Sulfa___
Latex___ Other_____
_____
_____

Consent for Treatment

By my signature below, I authorize Dr.Johnson, Dr. Mills and Dr. Evetts to take x-rays, perform dental surgery, administer anesthetic, and provide the dental treatment explained to me in the treatment plan. My signature also verifies my knowledge and understanding of the treatment to be provided. I understand that dentistry, as in all medical treatments, is not an exact science and results of any treatments performed may vary from patient to patient and cannot be guaranteed. I understand that additional surgeries, treatments, or therapies may be required following the initial dental treatment, and I am granting my consent for any and all of these procedures by Dr. Johnson, Dr. Mills, Dr. Evetts, their hygienists, or assistants. Also, by my signature below I hereby certify the correctness and completeness of the medical history information I have provided above. I also understand that I am responsible for payment of all fees and costs resulting from my treatment. I understand that certain procedures may require additional consent.

Patient or Responsible Guardian_____ Date_____

Witness _____

Contemporary Family Dentistry

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our notice of privacy practices provides information about how we may use or disclose protected health information. By your signature, you ascertain that you have been offered a written HIPAA notice. The HIPAA law allows for the use of the information for treatment, payment, or healthcare operations. This includes but is not limited to sharing your information with primary care physicians, dental and medical specialists, and your insurance company in order to secure treatment and/or reimbursement for you, the patient.

Please Print Patient Name_____

Signature_____**Date**_____

Please list anyone that we may speak with regarding your health status, or finances. This notice will stand until another notice is signed and replaces the current one on file. All patients age 18 and over must list their parents if they want us to talk to them about appointments, treatments, and billing:

_____ _____

_____ _____

_____ _____

_____ _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign.
- ☐ Communications barriers prohibited obtaining the acknowledgment.
- ☐ An emergency situation prevented us from obtaining acknowledgment.
- ☐ Other (Please Specify):

_____