Sweeny Family Dental

Date: _____

Patient First Name_____ MI___ Last Name_____

Address_____Zip_____

Parent/Guardian(if patient is a child)_____

Home Phone_____Work Phone_____Ext_____

Email_____Cell phone_____

Birth Date_____ Soc. Sec_____ Drivers Lic_____

Check One: ____Minor ____Single ____Married ____Divorced ____Widowed ____Separated

Patient/ Parent/Guardian Employer:_____Work Phone_____

Whom may we thank for referring you?_____

Person to contact if needed_____Phone_____

*****I give Sweeny Family Dental permission to discuss any information with the following person(s)

Name:_____Relationship_____

Name:_____Relationship_____

RESPONSIBLE PARTY

Name of Person Responsible for this Account_____

Address_____

Relationship to patient_____Home Phone_____

Cell Phone_____ Email_____

Drivers Lic_____ Birthdate_____ Soc Sec_____

Employer_____Work Phone_____

Is this person currently a patient in our office? ____Yes ____No

PAYMENT

For your convenience we offer the following methods of payment.

___Cash ___Personal Check ___Visa ___Master Card ___Discover ___Care Credit

INSURANCE INFORMATION—PLEASE PRESENT YOUR CARD

Insurance Company_____Name of Insured_____

Relationship to Patient_____Date of Birth_____SS#_____

Name of Employer_____ID#_____Group#_____

Provide a copy of your drivers licence & insurance card

*******PAYMENT IS DUE AT TIME OF SERVICE*******

Sweeny Family Dental

welcomes you!

FINANCIAL POLICY

We are committed to providing you with the best possible care and we will be pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy or your responsibility.

***We will verify and file most insurance as a courtesy. All unpaid claims are patient's responsibility.**

***FULL PAYMENT IS DUE AT TIME OF SERVICE.**

***A $25.00 BILLING CHARGE WILL BE ADDED MONTHLY AFTER YOUR ACCOUNT IS DELINQUENT 90 DAYS. This can easily be avoided by payment.**

***We accept cash, checks, Visa/MasterCard, (Debit cards with the visa/MasterCard logo) and Discover. We also offer Care Credit as a finance option if approved.

BE ADVISED-

It is our experience that Humana, Guardian, GEHA, United Health Care & some other insurance companies may not pay claims as estimated leaving a patient balance. This is your responsibility and payment for left over balance is expected immediately following claim payment, regardless of treatment done. Any dispute regarding insurance payment is to be discussed with your insurance company. We are happy to assist you in any way.

MISSED APPOINTMENTS / CANCELLED APPOINTMENTS

Missed or cancelled appointments are a loss for everyone. Our office policy requires a 24 hr. notice for all cancelled appointments. If you miss two appointments without prior notice, it becomes your responsibility to call and confirm the day before your appointment. Failure to confirm your appointment may result in the loss of your appointed time. Our objective is to provide quality service to ALL of our patients. Missed appointments by you translates to time another patient could be seen, as a result we may no longer be able to see you as a patient here.

_____ _____

Responsible Party Signature Date

HIPAA

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I know of Sweeny Family Dental Notice of Privacy Practices.

Signature_____ Date_____

Medical/ Dental History

Patient Medical / Dental History

Today's Date _____

Physician's Name and Address _____

Medical History

Are you currently under a physician's care? _____

If so, Why?

When was your last complete physical exam? _____

Are you taking any medications or health related substances? _____

If so, please list:

Are you allergic to any medications or substances? _____

If so, what?

Do you have asthma or other respiratory difficulties? _____

Have you ever had rheumatic fever? _____

Are you aware of any heart murmurs? _____

Do you have high blood pressure? _____

Do you have a pacemaker or artificial heart valve? _____

Do you have any other heart disease or condition? _____

Do you have any blood disorders such as anemia, leukemia, etc? _____

Have you ever bled excessively after being cut or injured? _____

Have you ever had a serious illness or major surgery? _____

If so, please explain

Have you ever had radiation treatment to your head or neck? _____

Do you have arthritis or rheumatism? _____

Do you have any artifical joints, implants or prosthesis? _____

Do you have any stomach problems? _____

Do you have any kidney problems? _____

Do you have an liver problems? _____

Are you a diabetic? _____

Do you have epilepsy or seizure disorder? _____

Do you have or have had venereal disease? _____

If so what and when? _____

Have you tested HIV positive? _____

Do you have AIDS? _____

Have you had or do you test positive for hepatitis? _____

Do you or have you had TB? _____

Are you currently pregnant or trying to get pregnant? _____

Do you smoke or use any other form of tobacco? _____

If so, what and how much?

Have you been or are you addicted to alcohol or drugs? _____

If so, what?

Have you had psychiatric treatment? _____

Is there anything else we should know about your health history? _____

If so, explain

Dental History

Are you happy with the appearance of your smile? _____

If not, what would you like to change?

Do you have any concerns about getting dentistry done?

If so, explain.

Are you aware of any problems in your mouth? _____

If so, what are these problems?

How long since your last dental visit? _____

When were your teeth last cleaned? _____

Do you clench or grind your teeth? _____

Does your jaw click or pop? _____

Do you have pain in the muscles of your face or around your ears? _____

Do you have any preference in regards to the type of fillings used? _____

If so, what would you like?

Do you have dental insurance? _____

Do you wish to use Nitrous Oxide during your dental treatment? _____

Signature

Photo Consent Form

I, _____ grant permission to **Sweeny Family Dental** for the use of the photograph(s) or electronic media images as identified below in any presentation of any and all kind whatsoever. I understand that I may revoke this authorization at any time by notifying **Sweeny Family Dental** in writing. The revocation will not affect any actions taken before the receipt of this written notification. Images will be stored in a secure location and only authorized staff will have access to them. They will be kept as long as they are relevant and after that time destroyed or archived.

Print name: _____

Signature: _____

Date: _____