

VALLEY DENTAL & ORTHODONTICS

Today's Date: _____

Patient Name: Mr. Mrs. Ms. Other (_____) _____ Patient's Birth Date: _____

Home address: _____

Home Telephone: _____ Work: _____ Cell: _____

E-mail Address: _____ Responsible Party: Name _____ Mother Father Legal Guardian

Patient Social Security # _____ Male Female Single Married Spouse's Name: _____

If Student, age 18 or older, Name & Address of School: _____

Whom May We Thank for Referring You? _____

Person to Contact Outside of Immediate Family in Case of Emergency:

Name: _____ Relationship: _____

Address: _____ Telephone # _____

DENTAL HISTORY

Reason for Today's Visit _____

Former Dentist _____ Date of Last Visit _____ Last X-rays _____

How often do you floss? _____ How often do you brush? _____

Are you Happy With the Way Your Teeth Look? _____ Do you Snore? _____ Comments _____

Check if You Have Had Problems with Any of the Following:

Bad Breath Food Collection Between Teeth Periodontal Treatment Sensitivity when Biting/Chewing

Bleeding Gums Grinding Teeth Sensitivity to Hot/Cold Sore or Growth in Mouth

Clicking or Popping Jaw Loose Teeth or Broken Fillings Sensitivity to Sweets TMJ Dysfunction

POLICY REGARDING INSURANCE AGREEMENT

Our office is please to accept your insurance assignment. We offer this service as a courtesy to our patients. However, it must be clearly understood that the "contract" is between the patient and the insurance company; the account thereby being the responsibility of the patient for any amount not paid by the insurance company.

Our office does NOT guarantee that the patient's insurance company will pay. We will perform our routine insurance billing procedures upon verification of coverage. However, if for some reason the patient's insurance claim is denied, the patient is then considered to be responsible for the full amount of each bill.

Our office will not enter into a "dispute" with an insurance company over any claim, although, we will work with the insurance company to sort out any confusion or questions, which might arise. We cooperate fully with the regulations and requests of the insurance companies. However, it will be the responsibility of the patient to handle any type of dispute over payment with the insurance company.

***It is customary to make arrangement for payment of fees at the time services are rendered. ***

FINANCE CHARGE: if I do not pay the entire New Balance within 25 days of the monthly billing date, a FINANCE CHARGE will be added to my account for the current monthly billing period. The FINANCE CHARGE, which is a periodic rate of 1.5% per month (ANNUAL PERCENTAGE RATE OF 18%), or a minimum charge of \$2.00 for a balance under \$134.00, is applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney's fees to effect collection of this account.

AUTHORIZATION AND ACKNOWLEDGEMENTS (Please Initial)

_____ I understand that I am responsible for all costs of dental treatment. I hereby authorize Valley Dental & Orthodontics to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical/dental history on the other side are correct to the best of my knowledge.

_____ I hereby acknowledge that there will be a charge for each appointment missed if a 24 Hour notice is not given.

_____ I hereby acknowledge that I will be charged \$35 on all returned checks.

_____ The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Person Responsible for Account: Name _____ Relationship _____

Signature of Responsible Party _____ Driver's License # _____ Date _____

MEDICAL HISTORY

Are You Currently Being Treated for Any Medical Problems? _____

Physician's Name & Location _____ Date of Last Visit _____

Have You Had Any Serious Illnesses or Operations? _____ If Yes, Describe _____

Have You Ever Had A Blood Transfusion? Yes No If Yes, Give Approximate Dates _____

Women, Are You Pregnant? Yes No Nursing? Yes No Taking Birth Control? Yes No

Have You Ever Had Any Of The Following?

- | | | | | | | | |
|-----|-------------------------|----------------|----------------------|-----|-------------------------|-----|---------------------|
| Y N | AIDS/HIV Positive | Y N | Cortisone Treatments | Y N | Hemophilia | Y N | Sinus Trouble |
| Y N | Anemia | Y N | Cough, Persistent | Y N | High Blood Pressures | Y N | Scarlet Fever |
| Y N | Arthritis | Y N | Cough Up Blood | Y N | Jaw Pain | Y N | Shortness of Breath |
| Y N | Artificial Heart Valves | Y N | Diabetes | Y N | Kidney Disease | Y N | Skin Rash |
| Y N | Artificial Joints | Y N | Epilepsy | Y N | Liver Disease/Hepatitis | Y N | Stroke |
| Y N | Asthma | Y N | Fainting | Y N | Mitral Valve Prolapse | Y N | Swelling of Feet |
| Y N | Back Problems | Y N | Fen-Phen | Y N | Nervous Problems | Y N | Thyroid Problems |
| Y N | Blood Disease | Y N | Glaucoma | Y N | Pacemaker | Y N | Tobacco Habit |
| Y N | Cancer | Y N | Headaches | Y N | Psychiatric Care | Y N | Tonsillitis |
| Y N | Chemical Dependency | Y N | Heart Murmur | Y N | Radiation Treatment | Y N | Tuberculosis |
| Y N | Chemotherapy | Y N | Heart Problems | Y N | Respiratory Disease | Y N | Ulcer |
| Y N | Circulatory Problems | Describe _____ | | Y N | Rheumatic Fever | Y N | Venereal Disease |

MEDICATIONS

List Medications You Are Currently Taking

ALLERGIES

(Check all that apply)

_____	Aspirin	_____	Metals
_____	Barbiturates (Sleeping Pills)	_____	Penicillin
_____	Codeine	_____	Sulfa
_____	Latex	_____	Other
_____	Local Anesthetic	_____	_____

The above information is accurate and complete to the best of my knowledge. I agree to advise Valley Dental & Orthodontics of any changes in my health history.

Signature of Patient / Parent or Legal Guardian of Minor Child

Date

FOR OFFICE USE ONLY – Medical History Update

Date	Comments	Staff	Patient
1. _____ / _____	_____	Initials _____	Initials _____
2. _____ / _____	_____	Initials _____	Initials _____
3. _____ / _____	_____	Initials _____	Initials _____
4. _____ / _____	_____	Initials _____	Initials _____
5. _____ / _____	_____	Initials _____	Initials _____
6. _____ / _____	_____	Initials _____	Initials _____