Welcome to Flint Family Dentistry

Patient Name: _____ Date of Birth_____ Social Security #_____

Address: _____ Sex: Male Female

Cell Phone: _____Home Phone: _____ Insurance Co._____

Insurance ID# _____ Secondary Insurance _____2nd Insurance ID # _____

Emergency contact name _____ Phone# _____Relation:_____

How did you hear about us _____ Do you have Children? Yes No How many? _____

Person responsible for account _____ Relation _____ Phone# _____

Social Security # _____ E-mail address: _____Marital Status_____

PATIENT MEDICAL HISTORY

Physician name: _____ Office Phone_____ date of last exam _____

1. Are you under medical treatment now? Yes No
2. Have you ever been hospitalized for any surgical operation, or serious illness? Yes No
3. Are you taking any medications including non prescription medicines? Yes No
   If yes, what medications: _____
   _____
4. Have you ever taken Fen-Phen/Redux? Yes No
5. Do you use tobacco? Yes No
6. Do you use Cocaine or illegal substance? Yes No
7. Are you wearing contact lenses? Yes No
8. Do you have a persistent cough or throat clearing, not associated with known illness? Yes No
9. Are you allergic or have had reactions to
   a. Local anesthetics Yes No
   b. Penicillin or other antibiotics Yes No
   c. Sulfa Drugs Yes No
   d. Barbiturates Yes No
   e. Sedatives Yes No
   f. Iodine Yes No
   g. Aspirin Yes No
   h. Latex Yes No
   i. Other _____
10. Women Only:
    a. are you pregnant or think you may be pregnant? Yes No
    b. Are you Nursing? Yes No
    c. Are you on birth control pills? Yes No

Do you have any of the following?

___High Blood pressure
___Cardiac pacemaker
___Stroke
___Fainting/Seizures
___Low blood pressure
___Glaucoma
___Leukemia
___Joint replacement/Implant
___Hepatitis/Jaundice
___Stomach troubles/ulcers
___Heart disease
___Easily winded
___Swollen ankles
___Frequently tired
___Emphysema
___Epilepsy/convulsions
___Arthritis
___Heart trouble
___Respiratory problems
___Sexually transmitted disease
___Chest Pain
___Rheumatic fever
___Angina
___Tuberculosis
___Anemia
___Cancer
___Liver disease
___Kidney diseases
___Aids or HIV
___Back problems
___Heart attack
___Heart murmur
___Hay fever
___Asthma
___Radiation therapy
___Recent weight loss
___Diabetes
___Thyroid problems
___Chemotherapy

PATIENT DENTAL HISTORY

1. Do your gums bleed while brushing or flossing? Yes No
2. Are your teeth sensitive to sweet, sour, hot or cold? Yes No
3. Do you have lumps or sores in or near your mouth? Yes No
4. Have you had head, neck or jaw injuries? Yes No
5. Do you clench or grind your teeth? Yes No
6. Have you had prolonged bleeding following extractions? Yes No
7. Do you bite your lip or cheeks frequently? Yes No
8. Have you ever had difficult extractions? Yes No
9. Have you had any orthodontic work? Yes No
10. Do you have frequent headaches? Yes No
11. How would you rate your smile? 1 2 3 4 5

Welcome to Flint Family Dentistry

Financial Agreement

The best dental health services are based on a friendly, mutual understanding between provider and patient. We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your benefits. In order to achieve this goal, we need your assistance, and your understanding of our payment policy.

ALL PAYMENTS, (CO-PAYS / DEDUCTABLES) ARE DUE AT THE TIME THAT SERVICES ARE RENDERED; PRIOR TO BEING SEATED.

We will gladly discuss your proposed treatment, charges and answer any questions relating to your insurance. You must realize however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range of most companies.
3. Not all services are covered benefits under all contracts. Some insurance companies arbitrarily select certain services that they will not cover.

We must emphasize that as your dental care provider, our relationship is with you, not your insurance company. While the filing of insurance forms is a service that we extend to our patients, all charges are you responsibility from the time of treatment.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for all services rendered. If account is not paid within 90 days of the date of service and no financial arrangement have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting you account.

I / guardian (if patient is a minor) agree to be fully responsible for total payment of treatment performed in this office. I understand and agree to abide by this financial agreement.

Missed appointments

Please remember, once an appointment has been made, this time has been reserved specifically for you. If you need to cancel or reschedule your appointment please do so more than 24 hours in advance. Any appointments cancelled or rescheduled **less than 24 hours prior to the scheduled date**, will be considered missed appointment. **After 3 missed appointments**, there will be a **$35 charge** for all subsequent missed appointment.

Authorization, Release, and Agreement to pay for services rendered

I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered and understand it is my responsibility to inform this office of any changes to the information I have provided. I understand that providing incorrect information can be dangerous to my health. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the dentist to release any information including the diagnosis and the record of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or other health practitioners. I authorize and hereby request my insurance company to pay directly to the dentist (or dental group) insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered or my dependents.

Signature _____ Date _____