

**Patient Information Form  
Bull Shoals Family Dental**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First MI (Preferred Name)

Mailing Address: \_\_\_\_\_  
Street or P.O. Box City/State Zip code

Sex (M or F): \_\_\_\_ Marital Status: \_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ Phone (Work): \_\_\_\_\_ Cell: \_\_\_\_\_

DL#: \_\_\_\_\_ State: \_\_\_\_ Email \_\_\_\_\_

Are any other immediate family members patients here? \_\_\_\_ If so, who? \_\_\_\_\_

**Responsible Party**

Person responsible for the account \_\_\_\_\_ Relationship \_\_\_\_\_

Social Security Number \_\_\_\_\_ DOB \_\_\_\_\_ Phone Number \_\_\_\_\_

Mailing Address \_\_\_\_\_  
Street/P.O. Box City/State Zip code

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Dental Insurance Authorization**

If you have dental insurance, please provide us with the active dental insurance card.  
We cannot accept or bill medical insurance or medicare

I authorize my insurance company to pay the dentist all insurance benefits rendered.  
I authorize the use of this electronic signature on all insurance submissions.  
I authorize the dentist to release all information necessary to secure the payment of benefits.  
I understand that I am financially responsible for all charges whether or not paid by insurance.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## Consent for Services and Financial Policy

Patient Name \_\_\_\_\_

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of 3 months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I allow this practice to disclose my Protective Health Information to the following individuals: (This information could include: Name, Diagnosis, Test Results, Images and Account Information.)

I authorize the staff of Bull Shoals Family Dental to release information to the following:

1. \_\_\_\_\_

Name

Relationship

2. \_\_\_\_\_

Name

Relationship

3. \_\_\_\_\_

Name

Relationship

I have read and understand the above information and agree with its contents.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

**Health Information**(check all that apply)

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Acid Reflux          | <input type="checkbox"/> ADHD                | <input type="checkbox"/> Allergies-Seasonal  | <input type="checkbox"/> Allergy Amoxicillin  |
| <input type="checkbox"/> Allergy Asprin       | <input type="checkbox"/> Allergy Clindamycin | <input type="checkbox"/> Allergy Codeine     | <input type="checkbox"/> Allergy Epinephrine  |
| <input type="checkbox"/> Allergy Hydrocodone  | <input type="checkbox"/> Allergy Keflex      | <input type="checkbox"/> Allergy Latex       | <input type="checkbox"/> Allergy Nickel       |
| <input type="checkbox"/> Allergy Penicillin   | <input type="checkbox"/> Allergy Sulfa Drugs | <input type="checkbox"/> Allergy Tylenol     | <input type="checkbox"/> Anemia               |
| <input type="checkbox"/> Anxiety/Panic attack | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Artificial Joints   | <input type="checkbox"/> ArtificialHeartValve |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Auto Immune Disease | <input type="checkbox"/> Bipolar             | <input type="checkbox"/> Blood Thinner        |
| <input type="checkbox"/> Cancer-active        | <input type="checkbox"/> Cancer-Treated/Free | <input type="checkbox"/> Cerebral Palsy      | <input type="checkbox"/> COPD                 |
| <input type="checkbox"/> CPAP user            | <input type="checkbox"/> Dementia            | <input type="checkbox"/> Depression          | <input type="checkbox"/> Diabetes             |
| <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Fever Blisters       |
| <input type="checkbox"/> Fibromyalgia         | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Head Injuries       | <input type="checkbox"/> Heart Attack         |
| <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol     |
| <input type="checkbox"/> HIV/AIDS             | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Mental Disorders     |
| <input type="checkbox"/> Migranes             | <input type="checkbox"/> Nervous Disorders   | <input type="checkbox"/> Nightguard User     | <input type="checkbox"/> Osteoporosis         |
| <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Pregnancy/Nursing   | <input type="checkbox"/> PTSD                | <input type="checkbox"/> Radiation Treatment  |
| <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever     | <input type="checkbox"/> Seizures            | <input type="checkbox"/> Sinus Problems       |
| <input type="checkbox"/> Sleep Apnea          | <input type="checkbox"/> Smoke Tobacco       | <input type="checkbox"/> Smokeless Tobacco   | <input type="checkbox"/> Stomach Problems     |
| <input type="checkbox"/> Stroke               | <input type="checkbox"/> Thyroid disease     | <input type="checkbox"/> TMD/TMJ disorder    | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Tumors               | <input type="checkbox"/> Ulcers-oral         | <input type="checkbox"/> Ulcers-stomach      | <input type="checkbox"/> Venereal Disease     |

Please list any other medical condition, allergy, surgery, treatment or disease:

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List all medications you currently take (including Over The Counter drugs/supplements) or provide a list

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**Referral Information**

How were you referred to our practice? Please check one

- Another Patient (Who may we thank for the referral?) Name: \_\_\_\_\_
- Online search
- Website
- Insurance
- Phone Book
- Other (please let us know how you heard about us): \_\_\_\_\_

**Personal Information**

Briefly tell us about yourself (if you would like): \_\_\_\_\_

\_\_\_\_\_

Have you ever had a bad experience at the dentist? \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_ What is the reason for this visit? \_\_\_\_\_

Previous dentist's name and address: \_\_\_\_\_

Why did you leave your previous dentist? \_\_\_\_\_

When were X rays last taken of your teeth? \_\_\_\_\_

How frequently do you brush your teeth? \_\_\_\_\_ Soft or Hard bristle toothbrush? \_\_\_\_\_

- |     |    |  |     |    |  |
|-----|----|--|-----|----|--|
| Yes | No | Any concerns regarding your teeth?       | Yes | No | Have you lost any teeth?               |
| Yes | No | Do you clench or grind your teeth?       | Yes | No | Any tooth or jaw discomfort?           |
| Yes | No | Do you have snoring or sleeping issues?  | Yes | No | Have a click or pop in your jaw joint? |
| Yes | No | Are your teeth sensitive to hot or cold? | Yes | No | Any teeth uncomfortable to bite on?    |
| Yes | No | Interested in teeth whitening?           | Yes | No | Gums bleed when brushing or flossing?  |
| Yes | No | Do you like your smile?                  | Yes | No | Do you smoke or use tobacco?           |

Are there any conditions or concerns about your health that we need to discuss that have not been covered

in this questionnaire? \_\_\_\_\_

\_\_\_\_\_