Medical History

Patient Name: ______________________ Birth Date: ____________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question			
Are you under a physican's care now?	❍ Yes	❍ No	If yes
Have you ever been hospitalized or had a major operation?	❍ Yes	❍ No	If yes
Have you ever had a serious head or neck injury?	❍ Yes	❍ No	If yes
Are you taking any medications, pills, or drugs?	❍ Yes	❍ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	❍ Yes	❍ No	If yes
Do you use tobacco?	❍ Yes	❍ No	

Women: Are you . . .

❑ Pregnant/Trying to get pregnant? ❑ Nursing? ❑ Taking oral contraceptives?

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic
❑ Metal ❑ Latex ❑ Sulfa Drugs ❑ Local Anesthetics

Question			
Any Other Known Allergies?	❍ Yes	❍ No	If yes
Do you use controlled substances?	❍ Yes	❍ No	If yes

Do you have, or have you had, any of the following?

Condition			Condition			Condition			Condition		
Hemophilia	❍Yes	❍No	Radiation Treatments	❍Yes	❍No	Alzheimer's Disease	❍Yes	❍No	Diabetes	❍Yes	❍No
Recent Weight Loss	❍Yes	❍No	Anaphylaxis	❍Yes	❍No	Renal Dialysis	❍Yes	❍No	Anemia	❍Yes	❍No
Herpes	❍Yes	❍No	Rheumatic Fever	❍Yes	❍No	Angina	❍Yes	❍No	Emphysema	❍Yes	❍No
High Blood Pressure	❍Yes	❍No	Rheumatism	❍Yes	❍No	Arthritis/Gout	❍Yes	❍No	Epilepsy or Seizures	❍Yes	❍No
High Cholesterol	❍Yes	❍No	Scarlet Fever	❍Yes	❍No	Artificial Heart Valve	❍Yes	❍No	Excessive Bleeding	❍Yes	❍No
Hives or Rash	❍Yes	❍No	Shingles	❍Yes	❍No	Artificial Joint	❍Yes	❍No	Hypoglycemia	❍Yes	❍No
Sickle Cell Disease	❍Yes	❍No	Asthma	❍Yes	❍No	Fainting Spells/Dizziness	❍Yes	❍No	Irregular Heartbeat	❍Yes	❍No
Sinus Trouble	❍Yes	❍No	Blood Disease	❍Yes	❍No	Frequent Cough	❍Yes	❍No	Kidney Problems	❍Yes	❍No
Spina Bifida	❍Yes	❍No	Blood Transfusion	❍Yes	❍No	Frequent Diarrhea	❍Yes	❍No	Leukemia	❍Yes	❍No
Stomach/Intestinal Disease	❍Yes	❍No	Breathing Problems	❍Yes	❍No	Frequent Headaches	❍Yes	❍No	Liver Disease	❍Yes	❍No
Stroke	❍Yes	❍No	Bruise Easily	❍Yes	❍No	Glaucoma	❍Yes	❍No	Low Blood Pressure	❍Yes	❍No
Swelling of Limbs	❍Yes	❍No	Cancer	❍Yes	❍No	Hay Fever	❍Yes	❍No	Lung Disease	❍Yes	❍No
Thyroid Disease	❍Yes	❍No	Chemotherapy	❍Yes	❍No	Heart Attack/Failure	❍Yes	❍No	Mitral Valve Prolapse	❍Yes	❍No
Tonsillitis	❍Yes	❍No	Chest Pains	❍Yes	❍No	Heart Murmur	❍Yes	❍No	Osteoporosis	❍Yes	❍No
Tuberculosis	❍Yes	❍No	Cold Sores/Fever Blisters	❍Yes	❍No	Ulcers	❍Yes	❍No	Pain in Jaw Joints	❍Yes	❍No
Congenital Heart Disorder	❍Yes	❍No	Parathyroid Disease	❍Yes	❍No	Behavior Disorder	❍Yes	❍No	Psychiatric Care	❍Yes	❍No
Venereal Disease	❍Yes	❍No	HIV positive	❍Yes	❍No	Organ Transplant	❍Yes	❍No	ADHD	❍Yes	❍No
Autism	❍Yes	❍No	Heart Disease/Condition	❍Yes	❍No	Hepatitis A B or C	❍Yes	❍No	Alcoholism	❍Yes	❍No
Multiple Sclerosis	❍Yes	❍No	Lupus	❍Yes	❍No	Dementia	❍Yes	❍No	Bacterial Endocarditis	❍Yes	❍No
Pacemaker	❍Yes	❍No	Jaundice	❍Yes	❍No				Splenectomy	❍Yes	❍No

Have you ever had any serious illness not listed above? ❍ Yes ❍ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: ______________________ Date: ____________

Patient Information

(Confidential)

Name ______________________ Birth Date__________ SS#__________________

Address ______________________ City______________ State______Zip________

Home Phone ______________Cell Phone ______________ Confirm appts by: call or text

Employer______________________________________ Work Phone ______________

Name of Previous Dentist____________________ Date of Last Exam ______________

If Minor, Father's Name__________________Mother's Name ____________________

If Student, Name of School/College ______________________________________

Name of Spouse ____________________________________ SS#__________________

Spouse's Employer____________________________ Spouse's Birth Date__________

Whom may we thank for referring you? ______________________________________

Responsible Party

Name____________________________ Birth Date__________SS#__________________

Relationship to Patient ________________________ Phone ______________________

Address ____________________________ City_____________ State _____Zip________

Employer____

Insurance Information

Name of Insured____________________________________ Birth Date ______________

ID/SS# ________________ Name of Employer ____________________________________

Authorization and Release

Payment is due in full at the time of treatment unless prior arrangements have been approved. This office accepts insurance. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payments directly to DeWitt Family Dentistry of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company. I understand that the information given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the staff at DeWitt Family Dentistry to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

X____ Date ____________________

Signature of patient (or parent if a minor)

923 6th Avenue
DeWitt, Iowa 52742

Written Financial Policy

Thank you for choosing DeWitt Family Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

-Cash, Check, or Credit Card

We offer a 5% courtesy discount to patients who pay for their treatment at the time of service or prior to completion of care.

-Convenient monthly payment options from CareCredit Healthcare Credit Card

Allows you to pay over time

No annual fees or pre-payment penalties

Please note:

DeWitt Family Dentistry requires payment at the completion of your treatment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.

A fee of $25 is charged for patients who miss or cancel more than 2 times in a calendar year without 24-hour notice.

DeWitt Family Dentistry charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

____

Patient, Parent or Guardian Signature Date

____

Patient Name (Please Print)

-CareCredit Healthcare Credit Card is subject to credit approval.

-However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of you benefits directly from you insurance carrier.

923 6th Avenue
DeWitt, Iowa 52742

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for the following:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers and confirm coverage.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Confirm appointments using voicemail, postcards, or letters.
- Disclose health information to a family member, friend, or caregiver to the extent necessary to help with your healthcare.

I acknowledge that I have read and/or received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ____________________ Please print your children's first and last names below:

Signature of Patient: ____________________ ____________________
(or Personal Representative) ____________________

____

Date: ____________________ ____________________

For Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: ____________ Initials: ____________

_____ Individual refused to sign _____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement _____ Other (please specify)

____

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