"Thank you for helping us raise the Barr in dentistry! We will strive to provide you with the best possible dental care. To help us meet all your dental needs, please take your time to fill out this form completely. If you should have any questions, please do not hesitate to ask. We will be happy to help."

Patient Information (Confidential)

Date _____ Gender_____ SSN_____-_____-_____Age_____

Name _____ Birthday_____Home Number_____

Address_____City_____State_____Zip_____

Employer_____Work Phone_____

Spouse or Parent's Name_____Emergency Contact_____

Whom may we thank for referring you?_____

Email Address: _____ Texting: Yes___ No___ Cell#_____

(This is how we will confirm your appointments)

Responsible Party

Person responsible for account_____Relationship to Patient_____

Address_____Phone Number_____

Birthday_____ SSN_____-_____-_____

Insurance Information

Name of Subscriber_____Relationship to Patient_____

Subscriber's birthday_____SSN or ID#_____

Name of Employer_____Work Number_____

Insurance Company_____Group#_____Phone_____

Insurance Company Address_____City_____State_____Zip_____

Do You Have Additional Insurance?

Yes_____ No _____ If yes, please complete the following:

Name of Insured_____Relationship to Patient_____

Insured's birthday_____SSN or ID#_____

Name of Employer_____Work Number_____

Insurance Company_____Group#_____Phone_____

Insurance Company Address_____City_____State_____Zip_____

CASH – CHECK – VISA – MASTERCARD

AMERICAN EXPRESS – CARE CREDIT

Payment in full is due at the time services are rendered.

INSURANCE

Your insurance is a contract between you and the insurance company and it is your responsibility to know your insurance benefits.

As a courtesy we will bill both your primary and secondary insurance companies. We will submit your claims and assist you in any way we reasonably can to help get your claims processed. In order to do this, we must receive all the information necessary to bill. If the information is not supplied, you will be billed, and payment in full will be your responsibility and will be expected within 30 days or receipt of statement.

RETURNED CHECKS

Any checks returned to our office due to non-sufficient funds (NSF) will be charged a fee of $35.

LAST MINUTE CANCELLATIONS OR MISSED APPOINTMENTS

Our practice is dedicated to quality care and exceptional service. We respect the importance of your time and work very hard to schedule appointments that accommodate the busy scheduling needs of all out patients. In return, we ask that patients make every effort not to change reserved dental appointments. Also, missed or broken appointments interfere with your dental treatment. If an appointment needs to be changed, we require at least a 48-**hour** notice so that we may accommodate other patients. If a patient cancels an appointment with less than 48-hour notice, two times, the patient will be placed on the "quick call" list. Being on the "quick call" list means our office will do everything to help the patient get scheduled if there is a same day cancellation on the schedule. Unfortunately, no advanced appointments will be made for these cases. If a patient confirms an appointment and no shows, the patient will be placed on the quick call list. If an appointment is made from the quick call list, and the patient does not show, no further appointments will be made for that patient.

PAYMENT

As a patient, or legal guardian of a minor patient, I have read and understand the financial policy stated above. I agree to pay, promptly and in full. Any amounts due to the provider, including any amounts due for non-covered or services above the maximum allowed amount that are not payable by the insurance.

Other payment options and payment plans may be available upon request.

I (we) herby authorize Barr Family Dentistry to furnish my (our) Insurance Company (Companies) all information required concerning my (our) dental care. I herby assign to Barr Family Dentistry, all payments to which I may be entitled for dental expenses and do hereby direct that payment for such expenses be paid directly to Barr Family Dentistry.

_____

Signature of Patient or Legal Guard Date

Print Name _____

PATIENT MEDICAL HISTORY Patient Name _____

PHYSICIAN'S NAME _____ PHONE NUMBER _____

Have you been treated for the following? Please circle Y or N:

AIDS/HIV	Y	N
Anemia	Y	N
Artificial Joints/Implants	Y	N
If yes, please list part/date: _____		
Artificial Heart Valves	Y	N
If yes, please list type/date: _____		
Back/Neck Injury	Y	N
Asthma	Y	N
Cancer	Y	N
If yes, please list type/date: _____		
Chemical Dependency	Y	N
Chemotherapy/Radiation	Y	N
Diabetes If yes, which one? I or II	Y	N
Emphysema	Y	N
Epilepsy	Y	N
Fainting/Dizziness	Y	N
Headaches	Y	N
Heart Attack If yes, when? _____	Y	N
Heart Disease	Y	N
Heart Murmur	Y	N
Heart Problems	Y	N
Hepatitis If yes, which one? A B C	Y	N
Tuberculosis If yes, when? _____	Y	N
Herpes/Cold Sore/Blister/Fever	Y	N
Hemophilia/Bleeding Disorder	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Stroke If yes, when? _____	Y	N
Kidney Disease	Y	N
Thyroid Problems	Y	N
Liver Disease	Y	N
Low Blood Pressure	Y	N
Mitral Valve Prolapse	Y	N
Scarlet Fever	Y	N
Psychiatric Care	Y	N
Arthritis, Rhuematism	Y	N
Blood Disease	Y	N

Others, Please List:

_____
_____
_____
_____

Are you allergic to or had any reactions to the following:

Local Anesthetics	Y	N
Penicillin	Y	N
Erythromycin	Y	N
Codeine	Y	N
Anti-inflammatory	Y	N
Acetaminophen	Y	N

Others, Please List: _____
_____
_____
_____

Do you use Tobacco? Y N
If yes, what type and how often? _____
Do you use Marijuana? Y N
If yes, how often? _____

Have you ever had prolong bleeding following an extraction? Y N
Are you currently taking any blood thinners? Y N
Are you currently or have you ever taken bisphosphonates? Y N
Do you have any sores or lumps in or near your mouth? Y N
Do you clench or grind your teeth? Y N
Do your gums bleed while flossing:? Y N
Do you wear dentures or partials? Y N
If yes, please list date of initial placement: _____
Are you interested in improving your smile with Teeth Whitening? Y N
Are you under any medical treatment now? Y N

Medication:	Treatment:
_____	_____
_____	_____
_____	_____
_____	_____
Blood pressure/Date Taken	
_____	_____

WOMEN: Are you pregnant? Y N
If yes, please list due date: _____
Are you taking any oral contraceptives? Y N
Are you nursing? Y N

Please list the reason for your visit today: _____
Please list your long term dental goals: _____
What is the name of your previous dentist/location? _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and results of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and or health practitioners. I authorize and 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 billed amount for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

→ _____
Signature of Patient (or parent if minor) Date

Reviewed by: _____ Updated: _____ Updated: _____ Updated: _____