ABBEVILLE FAMILY DENTISTRY

Patient Information

Today's Date: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____

SS #: _____

Birthdate: _____ Age: ____ Sex: __ M __ F

Home Address: _____

City: _____ State: _____ Zip: _____

Cell #: _____

Home/Other #:_____

Email Address: _____

How do you preferred to be contacted?
__ Phone __ Email __ Text

Occupation: _____

Employer/School: _____

__Single __Married __Divorced __Widowed __Separated

Other family members seen by us: _____

Previous/Present Dentist: _____
(Please Circle)

Last Visit Date: _____

Spouses Name: _____ DOB:_____

SS #: _____

Employer:_____

How did you hear about us?

_____

Whom may we thank for referring you?

_____

Insurance Coverage

Who is responsible for this account:

_____

Relationship to patient: _____

Primary Insurance:

Insurance Co Name: _____

Group #:_____

Insured's Name:_____

Relation:_____

Insured's DOB: _____ ID#:_____

Insured's Employer:_____

Secondary Insurance:

Insurance Co Name: _____
Group #:_____
Insured's Name:_____
Relation:_____
Insured's DOB: _____ Insured's ID#:_____
Insured's Employer:_____

Assignment and Release

I certify that I, and or my dependent(s) have insurance coverage with the listed insurance companies above and I assign directly to Dr. Melisa Peak all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions.
Dr. Melisa may use my health care information and may disclose such information to the above named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian, or Personal Representative

Date:_____ Relation to Patient:_____

I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductibles that my insurance does not cover.

_____
Signature Date

Medical History

Do you have a personal physician? __ Yes __ No

Physician's Name: _____

Phone #:_____ Date of last visit:_____

Are you currently under the care of a physician?
__ Yes __ No
Please explain: _____

Please check if you have had any of the following medical conditions:

	Abnormal Bleeding		High Blood Pressure
	Alcohol/Drug Abuse		HIV/AIDS
	Anemia		Hospitalized
	Arthritis		Kidney Disease
	Artificial Bones/Joints/Valves		Liver Disease
	Asthma		Low Blood Pressure
	Blood Disease		Mitral Valve Prolapse
	Bleeding abnormally		Nervous Problems
	Cancer/Chemotherapy		Pacemaker
	Type of Cancer:		Psychiatric Problems
	Colitis		Radiation Treatment
	Congenital Heart Defect		Rheumatic Fever
	Diabetes		Scarlet Fever
	Difficulty Breathing		Seizures
	Emphysema		Shortness of breath
	Epilepsy		Shingles
	Fainting Spells		Sickle Cell Disease
	Glaucoma		Sinus Problems
	Hay Fever		Stroke
	Heart Attack		Thyroid Problems
	Heart Murmur		Tuberculosis (TB)
	Heart Surgery		Tumor
	Hemophilia		Ulcer
	Hepatitis ___		Venereal Disease
	Herpes/Fever Blisters		

Please list any serious medical conditions and/or surgeries that you have ever had (if not checked above):

_____

_____

_____

For women:
Are you pregnant? __ Yes __ No Week #:_____
Are you nursing? __Yes __ No

Medications

Have you ever taken Fosamax, or any other bisphosphonate? __ Yes __ No

Please list all medications you are currently taking and correlating diagnosis:

_____

_____

_____

Pharmacy Name: _____

Phone #: _____

Allergies

__ Aspirin __ Latex __ Barbiturates
__ Codeine __ Iodine __ Dental Anesthetics
__ Penicillin __ Sulfa __ Metals

Other Allergies:_____

Dental History

Why have you come to the dentist today?

_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No
Are you currently in pain? ☐ Yes ☐ No Do your gums ever bleed? ☐ Yes ☐ No
Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No
Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No
Your current dental health is: ☐ Good ☐ Fair ☐ Poor
Do you like your smile? ☐ Yes ☐ No
Would you like whiter teeth? ☐ Yes ☐ No Fresher breath? ☐ Yes ☐ No
How many times a week do you floss? a day do you brush?
Type of bristles? ☐ Soft ☐ Medium ☐ Hard
Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

I understand that the information that I have 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 dental staff to perform any necessary dental services that I may need during my diagnosis and treatment with my informed consent.

_____
Signature Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

NEW PATIENT INSURANCE AND ACCOUNT INFORMATION

Understanding your insurance coverage can be challenging at times. Our goal is to assist in maximizing your benefits. We care for patients whom are covered by many insurance companies. Each pays an insurance premium for specific coverage, which fits the company budget. Each plan is slightly different, with lower premium plans covering fewer services and lower fees for services.
We encourage you to become familiar with your policy exclusions, deductibles, and required co-payments.

1. **Our courtesy service to you includes:**
   Filing your insurance within 24 hours of your visit and requesting payment of your benefits to our office.
2. **Electronically filing your insurance claim, when possible.**
3. **Re-filing your insurance a second time at 30 days and a final time at 60 days.**
4. **Following the American Dental Association guidelines for coding procedures and filing insurance.**

Our expectations of you:

1. **Payment of fees not covered by your insurance plan at the time the service is delivered.**
2. **Understanding that the insurance policy belongs to you, and we have no leverage to obtain payment from your insurance carrier.**
3. **Keeping our office informed of insurance policy changes in your insurance coverage or employment.**
4. **Taking responsibility for payment if the insurance company does not pay our office within 75 days.**
5. **All accounts are subject to a collection fee in the event our collection agency must be involved.**
6. **All returned checks have a $35.00 fee.**

To assist us in obtaining your benefits, please sign the "assignment of benefits" below allowing us to file your insurance claims. Also, please have your insurance card ready for us to copy for our files.

I hereby authorize Abbeville Family Dentistry, the office of Dr. Melisa Adams Peak, DMD, to release to my insurance company and any other collection agency, information acquired during my dental care. I hereby authorize benefits to be paid directly to the office of Dr. Melisa Adams Peak, DMD.

_____ _____

Signature of Patient/Insured Date

PATIENT CONSENT FORM

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

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you and your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the Organization at any time to obtain a copy of the Notice of Privacy Practices.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

CONSENT FOR TREATMENT: I hereby grant authority to the dentist in charge of the care of the patient whose name is on this form, to administer anesthetics, analgesics, sedatives, and nitrous oxide sedation and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics, and/or medications.

Patient Name: _____

Relationship to Patient: _____

Signature: _____Date: _____