OLDROYD FAMILY DENTISTRY

Today's Date: _____

Name: _____ Preferred Name: _____

Date of Birth: ___-___-___ Age: _____

Legal/Sex at Birth: Female Male Gender Identity if applicable: _____

Address: _____ Apt.# _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

E-mail: _____

Preferred method of contact for appointment confirmation (circle): Call Text E-mail

Employer: _____ Occupation: _____

Last Dental Visit: _____ Last teeth cleaning? _____

How did you hear about us? _____ Reason for today's visit? _____

EMERGENCY INFORMATION

Person to contact/Relationship: _____ Phone Number: _____

DENTAL INSURANCE INFORMATION/ FINANCIAL POLICY

Subscriber Name: _____ Relationship to Subscriber: _____

Subscriber DOB: ___/___/___ Subscriber ID/SSN: ___-_____-_____ Subscriber's Employer: _____

Insurance company: _____ Group #: _____

*Payment is expected at time of service. We do accept insurance assignment but the patient portion is due at each visit. We do not send monthly bills. While we are contracted with several insurance companies, we accept all insurances as an out-of-network provider. Ultimately, you are responsible for payment of all fees for dental care rendered by our office.

METHODS OF PAYMENT (please circle one)

Cash Check Credit Card Care Credit Citi Health Card

OFFICE POLICY- BROKEN APPOINTMENTS AND CANCELLATIONS

At Oldroyd Family Dentistry we schedule our patients for treatment exclusively with the doctor or hygienist at a certain time and therefore ask that you be on time for your appointments. We will make every effort to contact you the day before your appointment as a reminder, but we often must leave you a message. There will be a $50-$100 charge for cancellations and broken appointments with less than 24 hours notice.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I have read and understand the financial policy and office policy. Should further information be needed you have my permission to ask the respective health care provider who may release such information to you. I will notify the doctor of any change in my health or medication.

_____ _____

Signature of Patient, Parent or Guardian Date

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MEDICAL HISTORY

Physicians Name: _____ Phone Number: _____

Please list all medications: _____

Pharmacy: _____ Phone number: _____

Are you currently pregnant? Yes No N/A How many months? _____

Are you taking birth control? Yes No N/A

Allergies- please circle if you're allergic to any of the following:

Aspirin	Local Anesthetics	Codeine/other narcotics
Latex Sensitivity	Penicillin	Other Antibiotic_____
Ibuprofen	Sulfa Drugs	Other_____

Do you have, or have you had any of the following? (please circle)

AIDS/HIV positive	Congenital Heart Disease	Mitral Valve Prolapse
Alzheimer's Disease	Diabetes, Type I or Type 2	Neck Ache
Anaphylaxis	Emphysema	Pacemaker
Artificial Heart Valve	Epilepsy or Seizures	Radiation Treatments
Artificial Joint:	Dizziness	Sickle Cell Disease
Hip	Glaucoma	Sinus Trouble
Knee	Headaches	Smoking/Tobacco Use:
Other	Hearing Loss	How many years____
Asthma	Heart Concerns	Snoring
Bell's Palsy	Heart Murmur	Stroke
Bleeding disorder	Hepatitis: Type ____	Thyroid Disease
Cancer	High Blood Pressure	Trigeminal Neuralgia
Chemotherapy	Kidney Problems	Tuberculosis

Do you have, or have you had any disease, condition or problem not listed?

_____

DENTAL HISTORY

Are you nervous about seeing a dentist? Yes No

If yes, please tell us why: _____

How often do you brush? _____ How often do you floss? _____

Please circle each that applies to you

Clenching	Headaches	Jaw Popping
Difficulty Chewing	I wear a night guard	My gums bleed
Difficulty Swallowing	I've had braces	My breath concerns me
Dry Mouth	Interested in whitening	Previous gum surgery
Food packs between my teeth	Interested in orthodontics	Sensitive teeth
Grinding	Jaw Pain	

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HIPAA
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICY

*YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, _____, have reviewed a copy of this office's Notice of Privacy Practices.

_____
Patient's Name (*please print*)

_____
Signature of Patient (parent or guardian if child)

_____
Date

_____
_____FOR OFFICE USE ONLY _____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not obtained because:

( ) Individual refused to sign

( ) Communication barriers prohibited obtaining the acknowledgement

( ) An emergency situation prevented us form obtaining acknowledgment

( ) Other (please specify

_____
_____
_____