Complete Family Dentistry, P.C.
1730 M St.
Ord NE 68862
(308)728-5672

# Patient Information

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____
_____ (City) _____ (State) _____ (Zip Code)

Preferred way for appointment confirmation (Choose One):

◯ Text ◯ E-mail ◯ Post Card

# Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____
_____ (City) _____ (State) _____ (Zip Code)

Whom may we thank for referring you to our practice?

_____

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# Medical History

Primary care physician's name, address, & phone number:

Preferred pharmacy, address, & phone number:

Please mark any of the following to indicate Yes in response to the question:

- ☐ Have you ever had complications following dental treatment?
- ☐ Are you currently under the care of a physician due to a specific condition?
- ☐ Have you been hospitalized within the last 5 years due to a surgery or illness?
- ☐ Do you use tobacco (smoking or chewing)?

If any of the previous questions are marked, please explain:

Are you currently taking any prescription or non-prescription drugs? Please list below:

## Women Only

Are you pregnant?

◯ Yes ◯ No

If Yes, when is your due date?

Are you currently taking Birth Control?

◯ Yes ◯ No

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Please indicate if you have or have had any of the following: (Checking the box will indicate a Yes response)

| | | |
|---|---|---|
| ☐ *Pre-Med- Amox | ☐ *Pre-Med- Clind | ☐ *Pre-Med- Other |
| ☐ Allergy- Aspirin | ☐ Allergy- Codeine | ☐ Allergy- Epinephrine |
| ☐ Allergy- Erythro | ☐ Allergy- Latex | ☐ Allergy- Other Meds |
| ☐ Allergy- Penicillin | ☐ Allergy- Seasonal | ☐ Allergy- Sulfa |
| ☐ Anemia | ☐ Arthritis | ☐ Artificial Joints |
| ☐ Asthma | ☐ Blood Disease | ☐ Blood Thinners |
| ☐ Cancer- Chemo Tx | ☐ Cancer- Radiation Tx | ☐ Cancer |
| ☐ Coumadin/Plavix | ☐ Diabetes | ☐ Dizziness/Fainting |
| ☐ Excessive Bleeding | ☐ Glaucoma | ☐ Head Injuries |
| ☐ Heart Disease | ☐ Heart Murmur | ☐ Hepatitis |
| ☐ High Blood Pressure | ☐ High Cholesterol | ☐ HIV/AIDS |
| ☐ Jaundice | ☐ Kidney Disease | ☐ Liver Disease |
| ☐ Mental Disorders | ☐ Mitro-Value Prolapse | ☐ Nervous Disorders |
| ☐ Osteoporosis | ☐ Osteoporosis-Meds | ☐ Pacemaker |
| ☐ Respiratory Problems | ☐ Seizures/Epilepsy | ☐ Sinus Problems |
| ☐ Stomach Problems | ☐ Stroke | ☐ Thyroid Problems |
| ☐ Tuberculosis | ☐ Ulcers | ☐ z.- Other |

Do you have any other health issues or allergies that need further clarification?

| |
|---|
| |

* ☐ By checking this box, I certify that to the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

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# Dental History

What is the reason for your dental visit today?

Prior Dentist's name, address, & phone number:

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

Please mark any of the following to indicate Yes in response to the question:

☐ Are you experiencing pain with your teeth?
☐ Do your teeth experience sensitivity to cold or hot temperatures?
☐ Do your gums bleed when you brush or floss?
☐ Are any of your teeth loose, or are you concerned about any teeth loosening?
☐ Do you grind or clench your teeth (either consciously or during sleep)?
☐ Do you experience any jaw pain/discomfort?
☐ Do you or have you had orthodontic treatment (braces)?
☐ Do you have bad breath?
☐ Do you have dry mouth?
☐ Do you currently have any dental implants, dentures, or partials?
☐ Do you snore?
☐ Have you ever been diagnosed with sleep apnea?

If any of the previous questions are marked, please explain:

If you could change anything about your mouth, teeth, or smile, what would it be?

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# Privacy Acknowledgemen (HIPAA)

I understand that under the Health Insurance Portability & Account Ability Acct of 1996 (HIPAA), 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 on that treatment directly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician orders.

I acknowledge that I can see your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that 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 healthcare operations. I also understand you are not required to agree to my requested restriction, but if you do aggress then you are bound to abide by such restrictions.

☐ By checking this box, I understand the above information regarding the Notice of Privacy Practices and agree with its contents. This will serve as my electronic signature for the Privacy Acknowledgement (HIPAA) Form.

# Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. 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 have been made.

As a service to our patients, our office will be happy to file all insurance claims and assist in making collections from insurance companies. If insurance does not pay for a service or pays less then the cost of service, the balance is the patients responsibility. The doctor is not responsible for rejected claims, nor is the doctor responsible to know what your insurance policy covers or does not cover.

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written arrangements are satisfied.

In consideration for the professional services rendered to me by this practice, I further agree that the charges for the 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.

☐ By checking this box, I understand the above information regarding insurance and financial policies and agree with its contents. This will serve as my electronic signature for the Consent for Services and Financial Policy Form.

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# Primary Insurance Information

## Primary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____

_____ (City) _____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____

_____ (City) _____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____

_____ (City) _____ (State) _____ (Zip Code)

## Primary Medical Insurance:

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

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# Secondary Insurance Information

## Secondary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

## Secondary Medical Insurance:

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

☐ By checking this box,

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 changes whether or not paid by my insurance.

Response Date: _____