Abbott Family Dentistry LLC PATIENT NAME: PT#

PATIENT HEALTH HISTORY: PLEASE CHECK **Y** FOR YES AND **N** FOR NO TO ALL BELOW

Y	N		Y	N		Y	N	
O	O	HEART MURMUR	O	O	SICKLE CELL ANEMIA	O	O	SINUS TROUBLE
O	O	HEART FAILURE	O	O	DRUG ALLERGIES List below	O	O	TUBERCULOSIS (TB)
O	O	ANGINA PECTORIS	O	O	PENICILLIN ALLERGY	O	O	TUMOR, GROWTH or CANCER
O	O	HEART DISEASE or ATTACK	O	O	LATEX ALLERGY	O	O	CHEMO / RADIATION THERAPY
O	O	STROKE	O	O	ALLERGIC TO ANESTHETICS	O	O	HIV / AIDS
O	O	HEART SURGERY within 6mos	O	O	ALLERGIC TO SULFITES	O	O	HEMOPHILIA
O	O	RHEUMATIC FEVER	O	O	METHACRYLATE ALLERGY	O	O	ANEMIA
O	O	HIGH BLOOD PRESSURE	O	O	OTHER ALLERGIES list below	O	O	DIABETIC
O	O	ASTHMA	O	O	ARTHRITIS	O	O	GLAUCOMA
O	O	PHEN PHEN USE HISTORY	O	O	HEPATITIS &/or CARRIER	O	O	TOBACCO USE
O	O	JOINT SURGERY within 2yrs	O	O	THYROID PROBLEMS	O	O	DAILY ASPIRIN USER
O	O	OTHER SURGERY within 2yrs	O	O	KIDNEY PROBLEMS	O	O	PREGNANT
O	O	ARTIFICIAL JOINT	O	O	LIVER PROBLEMS	O	O	EPILEPSY &/or SEIZURES
O	O	OSTEOPOROSIS	O	O	TEETH WHITENING Last 2wks	O	O	DEMENTIA / ALZHEIMERS
O	O	MIGRAINES / HEADACHES	O	O	TMJ / JAW MUSCLE PAIN	O	O	SLEEP APNEA / SNORING

ARE YOU TAKING ANY DRUGS FOR OSTEOPOROSIS OR BONE DENSITY? _____

ARE YOU TAKING FOSAMAX OR ANY BISPHOSPHONATE DRUGS? _____

LIST OTHER DRUGS YOU ARE ALLERGIC TO : _____

LIST OTHER HEALTH PROBLEMS : _____

WHAT PRESCRIPTION DRUGS ARE YOU TAKING (Including Birth Control) ? _____

_____

WHAT NON-PRESCRIPTION DRUGS ARE YOU TAKING ? _____

DO YOU USE RECREATIONAL OR STREET DRUGS ? _____ if yes, please list _____

DO YOU HAVE ANY DENTAL CONCERNS YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR ? _____

DO YOU GIVE PERMISSION TO DISCUSS DENTAL TREATMENT WITH YOUR SPOUSE and/or PARENT ? _____

TREATMENT : I GIVE CONSENT FOR TREATMENT FOR MYSELF, OR THE PATIENT LISTED. IF AN EMERGENCY, I GIVE CONSENT FOR NECESSARY TREATMENT FOR TREATING THE EMERGENCY. I AGREE TO FOLLOW TREATMENT PLANS PROVIDED BY THE DOCTOR, INCLUDING ANY AND ALL POST CARE INSTRUCTIONS. I UNDERSTAND THAT ANY TREATMENT MAY CAUSE POST DISCOMFORT AND THAT THERE IS NO GUARANTEE OR WARRANTY FOR ANY SUCH TREATMENT. I WILL DISCLOSE MY COMPLETE HEALTH HISTORY PRIOR TO TREATMENT AND WILL PROVIDE ANY CHANGES.

INSURANCE : AS A NEW PATIENT, PAYMENT IS DUE AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE AFTER MY INITIAL VISIT. AS A COURTESY, Abbott Family Dentistry LLC WILL BILL MY PRIMARY INSURANCE. I WILL BE EXPECTED TO REMIT ANY DEDUCTIBLE &/or CO-PAY, IF APPLICABLE, AT TIME OF EACH VISIT. WHEN TIME PERMITS, Abbott Family Dentistry LLC MAY CONTACT MY INSURANCE TO VERIFY ELIGIBILITY AND ALSO ACQUIRE AN ESTIMATE OF DENTAL BENEFITS. ANY INFORMATION PROVIDED BY MY INSURANCE IS ONLY AN ESTIMATE AND NOT A GUARANTEE OF BENEFITS OR A GUARANTEE OF PAYMENT. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO UNDERSTAND THE SPECIFICS OF MY INSURANCE PLAN. I AM AWARE THAT MY INSURANCE PLAN MAY PAY AN ALTERNATE BENEFIT FOR ANY PROCEDURE AND I AM RESPONSIBLE FOR THE DIFFERENCE IN FEES. Abbott Family Dentistry LLC WILL NOT BE RESPONSIBLE FOR CONTACTING MY INSURANCE AT EACH VISIT TO VERIFY BENEFITS &/or ELIGIBILITY. IT IS ENTIRELY MY RESPONSIBILITY TO BE AWARE OF ANY CHANGES TO MY DENTAL BENEFITS &/or ELIGIBILITY FOR SAID BENEFITS. Abbott Family Dentistry LLC WILL NOT BE RESPONSIBLE FOR TRACKING THE AMOUNT OF INSURANCE BENEFITS REMAINING FOR ANY INSURANCE COVERAGE INCLUDING SECONDARY INSURANCE. IT IS MY RESPONSIBILITY TO BE AWARE IF I HAVE EXHAUSTED MY SAID INSURANCE BENEFITS.

PAYMENT : I UNDERSTAND THAT PAYMENT IS DUE AT TIME OF SERVICE. AFTER A CLAIM IS SUBMITTED ON MY BEHALF, MY BALANCE IS DUE WITHIN 45 DAYS OF TREATMENT WHETHER INSURANCE HAS MADE A PAYMENT OR NOT. THERE WILL BE A MINIMUM FEE OF $30.00 FOR ALL NON-SUFFICIENT ITEMS. AFTER 60 DAYS, PAST DUE ACCOUNTS WILL BEGIN TO ACCRUE INTEREST AT A MONTHLY RATE OF 0.8%, 10.5% APR. Abbott Family Dentistry LLC RESERVES THE RIGHT TO REPORT PAST DUE ACCOUNTS TO THE CREDIT BUREAU AND TO TRANSFER ACCOUNTS TO COLLECTIONS. IF SENT TO COLLECTIONS, INTEREST IS CALCULATED FROM DATE OF SERVICE.

APPOINTMENTS : IN THE EVENT THAT I AM UNABLE TO KEEP A SCHEDULED APPOINTMENT, I WILL INFORM Abbott Family Dentistry LLC AT LEAST TWO BUSINESS DAYS PRIOR TO MY SCHEDLUED APPOINTMENT. I UNDERSTAND THAT Abbott Family Dentistry LLC RESERVES THE RIGHT TO CHARGE A FEE FOR A BROKEN OR MISSED APPOINTMENT IN THE AMOUNT OF $100.00 PER HOUR or THE ESTIMATED FEE FOR MY VISIT, WHICHEVER IS LESS.

SIGNATURE _____ DATE _____