

# PARRISH FAMILY DENTISTRY

Today's date \_\_\_\_\_

**What would you like us to call you?** \_\_\_\_\_

Full Legal Name \_\_\_\_\_ **Birth Date** \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_ Email: \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

**Preferred Method of contact:** \_\_\_ Home \_\_\_ Cell \_\_\_ Email

Person to contact in case of emergency \_\_\_\_\_ Phone # \_\_\_\_\_

Person responsible for this account (if not you) \_\_\_\_\_

Name of Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

**Do any of the following conditions apply to you? If yes, you will need to take antibiotics 1 hour prior to ALL invasive dental procedures. (Check if Applies)**

\_\_\_\_\_ Heart Surgery in the last 6 months

\_\_\_\_\_ A completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention, during the first six (6) months after the procedure

\_\_\_\_\_ Any repaired congenital heart defect with residual defect at the site or adjacent to the site of a prosthetic patch or a prosthetic device

\_\_\_\_\_ Artificial heart valves

\_\_\_\_\_ History of Endocarditis

\_\_\_\_\_ A cardiac transplant that developed a heart valve problem

\_\_\_\_\_ The following congenital (present from birth) heart condition: unrepaired or incompletely repaired cyanotic congenital heart disease, including those with palliative shunts & conduits.

\_\_\_\_\_  
**Signature of Patient (Guardian)**

**Continue on Next Page**

# INSURANCE INFORMATION

Insurance name \_\_\_\_\_  
Policyholder's Name \_\_\_\_\_ Policyholder's Birth Date \_\_\_\_\_  
Policyholder's Social Security # \_\_\_\_\_  
Policyholder's Employer \_\_\_\_\_  
Member ID # or Subscriber ID # \_\_\_\_\_

## FINANCIAL POLICY

Parrish Family Dentistry is committed to providing you with the best possible care. We will do what we can to help you receive your maximum allowable benefits.

We will gladly discuss your proposed treatment and answer any questions related to your insurance. However, some things you need to remember:

1. Your insurance contract is between YOU, YOUR EMPLOYER and the INSURANCE COMPANY. We are **NOT** a party to that contract.
2. Filing insurance claims is a COURTESY we extend to our patients.
3. Not all services are covered benefits!
4. Any charges not paid by insurance is **YOUR RESPONSIBILITY** from the date the services are rendered.
5. You will most likely have a Co-pay!

**\*\*\*CO-PAYS ARE DUE AT THE TIME SERVICES ARE RENDERED. \*\*\***

Please let us know if you have questions. We are here to help!

\_\_\_\_\_  
Signature of Patient (Guardian)

\_\_\_\_\_  
Date

# MEDICAL HISTORY

## **CHECK ALL THAT APPLY:**

- High Blood Pressure
  - Are you currently taking any **BLOOD THINNERS**? (such as Aspirin, Plavix, Coumadin or Xarelto)
  - Have you ever taken **BONE DENSITY** drugs? (Such as limited to Boniva, Zometa, Fosamax)
  - Have you ever had radiation treatment in the **head/neck** area?
  - Are you **PREGNANT/NURSING**?
  - History of **FAINTING/SEIZURES**? Last episode \_\_\_\_\_
  - Bleeding problems?
  - Heart trouble/Pacemaker/AFIB/defribulator/ or stent?
  - Neurological Disease? (i.e. MS, Parkinson's, Alzheimer's, etc.)
  - Immunological disease? (i.e. HIV, Hepatitis, Lupus, AIDS, etc.)
  - Diabetes? Controlled? \_\_\_yes or \_\_\_no
  - Other Medical issue(s) not listed?
- 
- 

## **ARE YOU ALLERGIC TO:**

\_\_\_\_\_ Latex

\_\_\_\_\_ Metals

\_\_\_\_\_ Medications    which one (s): \_\_\_\_\_

**What are your dental concerns?** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Patient (Guardian)**

\_\_\_\_\_  
**Date**

**Continue on Next Page**

