





**GENERAL HEALTH QUESTIONNAIRE**

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_ / \_\_\_\_ / \_\_\_\_ AGE \_\_\_\_

► **Do you have or have you ever had:**

	Yes	No		Yes	No
Rheumatic fever			Asthma		
Congenital heart disease			Bronchitis/chronic cough		
Mitral valve prolapse			Shortness of breath		
Heart murmur			Emphysema		
Heart valve replacement			Chronic Obstructive Pulmonary Disease		
Prosthetic (artificial joints)			Recurrent sore throat		
High cholesterol			Sleep Apnea		
Angina (chest pain)			Tuberculosis		
Irregular heart beat			Sinus problems		
Coronary artery disease			Thyroid disease		
Heart disease/Heart attack			Glaucoma		
Cardiac pacemaker			Kidney disease		
Swelling of the ankles			Liver disease/Hepatitis		
High or Low blood pressure			Diabetes		
Stroke/TIA			Ulcers or colitis		
Bleeding problems			Gastrointestinal problems		
Anemia			Arthritis/ Joint pain/ Back problems		
Hemophilia			Cancer		
Seizures/Epilepsy			Radiation/Chemotherapy treatments		
Dizziness/Fainting			TMJ symptoms/treatment		
Sexually transmitted disease			Prostate problems		
HIV/AIDS			Osteoporosis		

► **Are you allergic to or have you had an adverse reaction to:**

	Yes	No		Yes	No
Local anesthetics			Sedatives, barbiturates		
Penicillin/Amoxicillin			Codeine		
Sulfa drugs			Other narcotics		
Other antibiotics			Aspirin or Ibuprofen		
Iodine/Betadine/Neosporin			Latex or adhesive tape		

Please list additional allergies: \_\_\_\_\_

► **Are you taking any of the following medications:**

	Yes	No		Yes	No
Any type of blood thinners			Diuretics/Water pills		
Aspirin or Ibuprofen			Insulin or oral anti-diabetic drugs		
Coumadin			Blood pressure medicine		
Vitamin E			Prednisone/steroids		
Glucosamine			Medication for osteoporosis		

Please list all current medications (use the reverse side if necessary) \_\_\_\_\_



# Important Information For Our Patients

## **Office Hours**

- Office hours are: Monday, Tuesday, Thursday 8:00 a.m.-5:00 p.m.  
Wednesday, Friday 9:00 a.m.-5:00 p.m.

## **Continuing Care**

- This practice is centered around prevention and optimum oral health. We discourage isolated, occasional treatment and recommend comprehensive treatment, continuing care and regular maintenance.

## **After Hours Emergency Care**

- Our practice provides a 24 hour telephone number for our patients of record. A patient of record has been seen and received treatment in the office within the last 18 months. If you are a patient of record in need of emergency dental care, you may call 685-0669.

## **Cancellations & Missed Appointments**

- We recognize that in today's busy world, adhering to a schedule is important in order to maximize time and meet the demands of daily life. With this in mind, we have developed a cancellation policy that is fair to both our patients and our practice. We strive to run according to schedule and respect our patients' time. Late cancellations (less than 48 hours notice), failed appointments, and late arrivals are disruptive to our schedule and inconvenience other patients. In order to maintain our schedule we request 48 hours notice of cancellation. In the instance of late cancellation or a failed appointment there may be an \$80 charge per hour of scheduled appointment time.

## **Education**

- An abundance of educational material is available in the office for your review. We will provide specific information as it relates to your dental needs. We welcome your questions about any dental products, services, or technology.

## **Technology**

- Digital radiography, intra-oral photography and Patient Education software are examples of the state of the art technology used in our office for diagnosis and treatment planning. Our patients appreciate the efficiency and accuracy of this technology and like being involved in the decision-making process.

## **Sterilization**

- Rest assured we follow all recommended sterilization procedures and are compliant with all OSHA regulations.

## **Investing in Your Dental Health**

- New studies have shown that investing in your oral health, in terms of both prevention and treatment, is not only good for function and aesthetics, but for overall health as well. We endeavor to provide our patients with the highest standard of care at an affordable price.

## **Payments & Insurance**

- Fees for services are due at the time treatment is rendered. Payment may be made in cash, check, or by credit card. We also offer financing through Care Credit. As a courtesy to our patients with dental insurance, we will file the appropriate claim forms. Assignment of benefits is to the patient or the insured.



## FINANCIAL INFORMATION FORM

### PATIENT INFORMATION

Name	_____	Male	___	Female	___
Address	_____				
E-mail address	_____				
Date of Birth	_____	Telephone#s	_____	_____	_____
		home	work	cell	
Place of Employment	_____	Occupation	_____	Soc. Sec. #	_____
Driver's License #	_____				

### GUARANTOR OF ACCOUNT

(if other than the patient)

Name	_____	Male	___	Female	___
Relationship to Patient	_____				
Address	_____				
E-mail address	_____				
Date of Birth	_____	Telephone#s	_____	_____	_____
		home	work	cell	
Place of Employment	_____	Occupation	_____	Soc. Sec. #	_____
Driver's License #	_____				

### DENTAL INSURANCE INFORMATION

Insurance Company Name	_____				
Claims Address	_____				
Group #	_____	Company Toll Free Phone #	_____		
Policy Holder's Name	_____				
Date of Birth	_____	SS #	_____	Employer	_____



## FINANCIAL RESPONSIBILITY

Thank you for choosing us as your dental care provider. The following information provides the basis for the financial aspect of your treatment. We sincerely desire to treat our patients in a pleasing and congenial atmosphere and find this can best be accomplished when a clear understanding exists regarding financial arrangements. Please contact the office at any time with questions regarding your financial responsibility.

- PAYMENT:** Fees for services are due when treatment is rendered. Payment may be made in cash, check, or by credit card.
- FINANCING:** We offer financing through CareCredit. Many options, including zero interest financing are available.
- PREPAYMENT COURTESY:** For qualified treatment plans, a 3% courtesy discount is given for payment in full by cash or check prior to the first treatment visit.
- INSURANCE:** If you have dental insurance, we will file the appropriate claim forms with your insurance company, provided you supply us with documented evidence of coverage, ie an insurance card. Assignment of benefits is to the patient or the insured. Although we make every effort to help you understand and obtain your benefits, we cannot guarantee your insurance provider will pay. The amount of reimbursement is determined by the insurance carrier. We do not accept responsibility for collecting on an insurance claim or for negotiating a settlement on a disputed claim.
- THIRD PARTY PAYMENT:** If the Guarantor of Account is someone other than the patient, financial arrangements must be made prior to treatment being provided.
- NON-PAYMENT:** In the event the charges incurred are not paid in full when due and collection action is instituted, the patient is responsible for the additional costs associated with such collection activity. The collection costs may include and are not limited to collection agency fees, attorney fees, court costs and/or any other expenses incurred in its collection as allowable by law.
- RETURNED CHECKS:** A \$25 processing fee will be charged for a returned check.
- INTEREST:** Any account remaining unpaid 30 days from date of service will be charged interest at the rate of 1.5% per month on any unpaid balance (18% per year) unless prior payment arrangements have been approved.
- CANCELLATION:** Patients are expected to notify the office at least 48 hours prior to their scheduled appointment if they cannot keep the appointment. Failure to properly notify the office may result in a charge of \$80 per hour of scheduled appointment time. Three non-notified missed appointments may result in dismissal from the practice.

### FINANCIAL RESPONSIBILITY AGREEMENT

I have read the financial responsibility for dental services, agree to the terms and accept full responsibility for all charges for services rendered.

Patient or Authorized Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_