NEW PATIENT INFORMATION

Section A__________Patient Information____

First Name: Last Name: Middle Initial:
Preferred Name:

Address:
Address 2:
City, State, Zip:
Home Phone:
Work Phone: Ext:
Cellular:
Sex: ☐Male ☐ Female
Marital Status: ☐ Married ☐ Single ☐ Divorced/Separated ☐ Widowed
Birth Date:
E-mail: ☐I would like to receive correspondences via e-mail.
Patient Is: ☐Policy Holder ☐Responsible Party (If Patient is the Responsible Party please skip to Section C)

Section B__________Responsible Party____

SKIP IF RESPONSIBLE PARTY IS PATIENT
First Name: Last Name: Middle Initial:
Address:
Address 2:
City, State, Zip:
Home Phone:
Work Phone: Ext:
Cellular:
Birth Date: Soc Sec:

Section C__________Emergency Contact____

Please provide an emergency contact:

Contact phone number:

Relationship:

Section D__________Medical History____

Although dental personnel primarily test the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain:

Have you ever been hospitalized/major operation? ☐Yes No If yes, please explain:

Have you ever had a serious head/neck injury? Yes No If yes, please explain:

Are you taking any medications/pills/drugs? Yes No If yes, please explain:

Do you take/have you taken Phen-Fen or Redux? Yes No If yes, please explain:

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?

Yes No If yes, please explain:

Are you on a special diet? Yes No Do you use tobacco? Yes No

Women: Are you…

Pregnant/Trying to conceive? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic

NEW PATIENT INFORMATION

Metal Latex Sulfa Drugs Local Anesthetics

Do you used a controlled substance? Yes No If yes, please explain:

Other? Yes No If yes, please explain:

Do you have, or have you had, any of the following?

	Y	N		Y	N		Y	N		Y	N
AIDS/HIV +	☐	☐	Cortisone Meds	☐	☐	Hemophilia	☐	☐	Radiation	☐	☐
Alzheimer's	☐	☐	Diabetes	☐	☐	Hepatitis A	☐	☐	Recent Weight Loss	☐	☐
Anaphylaxis	☐	☐	Drug Addiction	☐	☐	Hepatitis B/C	☐	☐	Renal Dialysis	☐	☐
Anemia	☐	☐	Easily Winded	☐	☐	Herpes	☐	☐	Rheumatic Fever	☐	☐
Angina	☐	☐	Emphysema	☐	☐	High Blood Pressure	☐	☐	Rheumatism	☐	☐
Arthritis/Gout	☐	☐	Epilepsy/Seizures	☐	☐	High Cholesterol	☐	☐	Scarlett Fever	☐	☐
Artificial Valve	☐	☐	Excessive Bleeding	☐	☐	Hives/Rash	☐	☐	Shingles	☐	☐
Artificial Joint	☐	☐	Excessive Thirst	☐	☐	Hypoglycemia	☐	☐	Sickle Cell	☐	☐
Asthma	☐	☐	Fainting/Dizziness	☐	☐	Irregular Heartbeat	☐	☐	Sinus Trouble	☐	☐
Blood Disease	☐	☐	Frequent Cough	☐	☐	Kidney Problems	☐	☐	Spina Bifida	☐	☐
Blood Transfusion	☐	☐	Diarrhea	☐	☐	Leukemia	☐	☐	Stomach/Intest. Disease	☐	☐
Breathing Problems	☐	☐	Headaches	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐
Bruise Easily	☐	☐	Genital Herpes	☐	☐	Low Blood Pressure	☐	☐	Limb Swelling	☐	☐
Cancer	☐	☐	Glaucoma	☐	☐	Lung Disease	☐	☐	Thyroid Disease	☐	☐
Chemotherapy	☐	☐	Hay Fever	☐	☐	Mitral Valve Prolapse	☐	☐	Tonsillitis	☐	☐
Chest Pains	☐	☐	Heart Attack/Failure	☐	☐	Osteoporosis	☐	☐	Tuberculosis	☐	☐
Cold Sores/Blisters	☐	☐	Heart Murmur	☐	☐	Pain in Jaw	☐	☐	Tumors/Growths	☐	☐
Congenital Heart Dis.	☐	☐	Pacemaker	☐	☐	Parathyroid Disease	☐	☐	Ulcers	☐	☐
Convulsions	☐	☐	Heart Disease	☐	☐	Psychiatric Care	☐	☐	Venereal Disease	☐	☐
Yellow Jaundice	☐	☐									

Have you ever had any serious illness not listed: Yes No If yes, please explain:

Section E__________Cancellation Policy____

We require 24 hours notice if you are not able to make it to your appointment.

We reserve the time for your appointments, and have a full staff waiting for you. We understand that things come up, but we would like as much notice as possible so that we may offer the appointment to other patients who are waiting to be seen. When we have less than 24 hours notice we are not always able to do this. *Please help us keep our prices down and our customer service high by giving us at least 24 hours notice. Regretfully, after three missed appointments, we will not be able to schedule you again in our office.*

- 1st no show or late cancellation: We will verbally remind you of our no show/cancellation policy.
- 2nd no show or late cancellation: We will send you a letter reminding you of our policy again.
- 3rd no show or late cancellation: We will no longer be able to schedule you in our office again. We will send you a letter ending our Doctor/Patient relationship.

If a family member has been sent a termination letter then the rest of the family will be under review and may also be sent a letter to end the Doctor/Patient relationship.

Please, let us know if there is anything we can do differently to help you keep your appointments. We are always happy to assist you and would be happy to reschedule your appointment for a time that better fits your schedule.

Section F___________Financial Agreement____

Frenchtown Dental is happy to be able to offer the following financial options for our patients to choose from:

1. Bill Insurance:

   a. Frenchtown Dental will bill you insurance. We provide the service of submitting your insurance claim and well as any information needed for you insurance company. Co-pays are due at the treatment appointment. You will be responsible for any outstanding balance.

2. Pre-payment for treatment;
   a. A 5% bookkeeping courtesy is available for those who pay the full cost of their treatment, with cash or check, before treatment is started.
3. Payment at time of appointment.
4. Major Credit Card:
   a. We accept Visa, MasterCard and Discover
5. In office financing through Care Credit:
   a. 6-12 month interest free financing is available through our health spending banking partner Care Credit, upon approval.

Please review the following statements:

- I understand that I am responsible for the full amount of service
- I assign my insurance benefits to Dr. Sanders – Frenchtown Dental
- I give my permission for Frenchtown Dental to disclose my account/ treatment information to appropriate agencies
- I understand that all balances shall be subject to a service charge of 5% per month until paid in full.
- I understand any treatment which does not have a payment plan shall be considered delinquent and subject for collection action if unpaid for 90 days or more from the date incurred. I am responsible for any collection fees including but not limited to- attorney fees, agency fees (up to 50% of my account balance may be added and I am responsible for that amount).
- I understand that a $30 fee will be applied for any returned checks
- I understand this form is valid unless I cancel the authorization through written notice.
- This document supersedes all previous financial agreements

By signing this document you are agreeing to the Cancelation Policy and Financial Agreement, as well as verifying that all of the above information is true and accurate:

Patient/Patient Representative Electronic Signature: ______________________________ **Date:** ________________