FOX CREEK
Family Dental

Medical History

Patient Name_____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a 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.

*Physician's Name*_____ *Physician's Phone#*_____

Are you under a physician's care now?	☐ Yes	☐No	If yes please explain: _____
Have you ever been hospitalized or had major operation?	☐ Yes	☐No	If yes please explain: _____
Have you ever had a serious head or neck injury?	☐ Yes	☐No	If yes please explain: _____
Do you take, or have you taken Oral Bisphosphonate Drugs	☐ Yes	☐No	If yes please explain: _____
Are you on a special diet?	☐ Yes	☐No	If yes please explain: _____
Do you use tobacco?	☐ Yes	☐No	If yes please explain: _____
Do you use controlled substances?	☐ Yes	☐No	

Women, are you: Pregnant or trying to get pregnant? ☐Yes ☐No Taking oral contraceptives? ☐Yes ☐No Nursing? ☐Yes ☐No

Are you allergic to any of the following?

☐Asprin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Anesthetics
☐Other If yes, please explain: _____

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

Aids/HIV Positive	☐ Yes	☐No	Cortisone Medicine	☐ Yes	☐No	Hemophilia	☐ Yes	☐No	Renal Dialysis	☐ Yes	☐No
Alzheimer's Disease	☐ Yes	☐No	Diabetes	☐ Yes	☐No	Hepatitis A	☐ Yes	☐No	Rheumatic Fever	☐ Yes	☐No
Anaphylaxis	☐ Yes	☐No	Drug Addiction	☐ Yes	☐No	Hepatitis B or C	☐ Yes	☐No	Rheumatism	☐ Yes	☐No
Anemia	☐ Yes	☐No	Easily Winded	☐ Yes	☐No	Herpes	☐ Yes	☐No	Scarlet Fever	☐ Yes	☐No
Angina	☐ Yes	☐No	Emphysema	☐ Yes	☐No	High Blood Pressure	☐ Yes	☐No	Shingles	☐ Yes	☐No
Arthritis/Gout	☐ Yes	☐No	Epilepsy or Seizures	☐ Yes	☐No	Hives or Rash	☐ Yes	☐No	Sickle Cell Disease	☐ Yes	☐No
Artificial Heart Valve	☐ Yes	☐No	Excessive Bleeding	☐ Yes	☐No	Hypoglycemia	☐ Yes	☐No	Sinus Trouble	☐ Yes	☐No
Artificial Joint	☐ Yes	☐No	Excessive Thirst	☐ Yes	☐No	Irregular Heartbeat	☐ Yes	☐No	Spina Bifida	☐ Yes	☐No
Asthma	☐ Yes	☐No	Fainting Spells/Dizziness	☐ Yes	☐No	Kidney Problems	☐ Yes	☐No	Stomach/Intestinal Disease	☐ Yes	☐No
Blood Disease	☐ Yes	☐No	Frequent Cough	☐ Yes	☐No	Leukemia	☐ Yes	☐No	Stroke	☐ Yes	☐No
Blood Transfusion	☐ Yes	☐No	Frequent Diarrhea	☐ Yes	☐No	Liver Disease	☐ Yes	☐No	Swelling of Limbs	☐ Yes	☐No
Breathing Problem	☐ Yes	☐No	Frequent Headaches	☐ Yes	☐No	Low Blood Pressure	☐ Yes	☐No	Thyroid Disease	☐ Yes	☐No
Bruise Easily	☐ Yes	☐No	Genital Herpes	☐ Yes	☐No	Lung Disease	☐ Yes	☐No	Tonsillitis	☐ Yes	☐No
Cancer	☐ Yes	☐No	Glaucoma	☐ Yes	☐No	Mitral Valve Prolapse	☐ Yes	☐No	Tuberculosis	☐ Yes	☐No
Chemotherapy	☐ Yes	☐No	Hay Fever	☐ Yes	☐No	Pain in Jaw Joints	☐ Yes	☐No	Tumors or Growths	☐ Yes	☐No
Chest Pains	☐ Yes	☐No	Heart Attack/Failure	☐ Yes	☐No	Parathyroid Disease	☐ Yes	☐No	Ulcers	☐ Yes	☐No
Cold Sores/Fever Blisters	☐ Yes	☐No	Heart Murmur	☐ Yes	☐No	Psychiatric Care	☐ Yes	☐No	Venereal Disease	☐ Yes	☐No
Congenital Heart Disorder	☐ Yes	☐No	Heart Pace Maker	☐ Yes	☐No	Radiation Treatments	☐ Yes	☐No	Yellow Jaundice	☐ Yes	☐No
Convulsions	☐ Yes	☐No	Heart Trouble/Disease	☐ Yes	☐No	Recent Weight Loss	☐ Yes	☐No		☐ Yes	☐No

Please list any condition not listed above:_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING AND FOR WHAT CONDITION

_____

_____

_____

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.SIGNATURE OF PATIENT,

PARENT, or GUARDIAN_____DATE_____

FOX CREEK FAMILY DENTAL

1610 PACE ST. UNIT #101
LONGMONT, CO 80504

I, _____, consent to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with doses, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

5. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

_____ _____

Patient or Guardian Name Date

FOX CREEK
Family Dental

Financial Policy

I. As a patient of Fox Creek Family Dental, you understand that you are responsible to pay for services and treatment provided by our office. We require that you pay your portion on the day services are rendered. If you would like to put your balance on your credit or debit card, we accept the following: **VISA, MasterCard, Discover & American Express**. We are happy to offer a flexible financing option through: Care Credit. For uninsured patients we offer our Dental Savings Plan.

II. You also understand that even if an estimate is given or a procedure has been pre-approved, you are responsible for any costs that your insurance company does not cover.

III. To accommodate our patient's time and busy schedule, we schedule exclusive appointments for each patient and always strive to stay on time. We sincerely ask that our patients respect this policy, and provide us with at least 48 hours notice if you are unable to keep the time we have reserved for your dental care. Appointments broken with less than 48 hours notice will be charge a cancellation fee of $50.

By signing below, I agree that I am fully responsible for the total payment of all procedures performed in this office. I understand that my portion for services is due in full at the time of service unless other financial arrangements have been signed. Any portions billed to my insurance are to be paid in full within 90 days from the date of service, regardless of whether or not my insurance has provided reimbursement or allow the submitted charges. Any balance not paid in full within 90 days will accumulate a charge of 10% per month and I will be responsible for my balance, all finance fees, all collection agency fees, and any additional costs associated with collecting the full balance on my account.

_____

Signature (responsible party) Print Name Date

FOX CREEK
Family Dental

Patient Information

Patient Name_____

Mailing Address_____City_____ State_____ Zip_____

Home Phone _____ Cell Phone_____

Work Phone_____ Email_____

_____

Birth Date ___/___/_____ Age_____ Sex: Male Female

Social Security_____ _ Driver's License_____

_____

Occupation _____ Business_____

If married, spouse' name _____ If child, parent's name _____

Emergency Contact_____ _____Phone Number_____ _

Address _____ Relationship to patient_____

How did you hear about our office?_____

Do you have any specific dental concerns?_____

If there was a way to straighten your teeth and improve your smile in a short period of time, is that something that You would be interested in talking about? _____

Dental Insurance Information

Name Of Insured _____Name of Employer _____

Member ID or SSN _____ Birth Date___/___/_____

Insurance Company_____ Group # _____

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes.

Patients who cancel appointments without at least 48 hour weekday notice will be charged a cancellation fee.

Patient Signature (parent if minor)_____ Date_____

_____

FOX CREEK
Family Dental

FOX CREEK FAMILY DENTAL

Insurance Policy

You are fortunate to have dental insurance, whether you have purchased it or your employer has provided it for you. Though your dental insurance is your responsibility we can help! We will go the extra mile to help you maximize your benefits. As a courtesy, we will help by filing your insurance forms, which will save you considerable time and trouble. We accept payments from most insurance companies, which reduces your immediate out-of-pocket expense.

Regardless of what we may calculate your insurance company to pay, it is only an estimate. Our estimate is based on limited information obtained from your insurance company. You must understand, we cannot forecast what they will pay. Should your coverage be less than anticipated, you will be responsible for the difference.

We must stress that you are responsible for the total treatment fee. Your dental insurance is not designed to pay the entire cost of your treatment, but it is intended to help cover a certain portion of the cost. Better terms for dental insurance may be "dental assistance" or "dental benefits."

Please remember, however, the financial obligation for dental treatment is between you and this office, and is not between this office and your insurance company.

I have read and understand the above and understand it is my responsibility to inform the office of any changes in my coverage.

Print Patient Name	Patient Signature	Date

FOX CREEK
Family Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice Of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specify)

_____
_____
_____

Authorization for Communication

FOX CREEK
Family Dental

I authorize the following information to be given to the following parties:

Name:_____

Name:_____

Name:_____

Initial all that apply:

____ Appointment confirmation calls - a voice mail may be left at on my contact phone numbers.

____ Appointment confirmation calls - you may speak with the above parties.

____ Financial information regarding my account - you may speak with the above parties.

____ Credits to my account may be transferred to the above parties account.

Patient
Signature:_____Date_____