LAYTON HILLS DENTAL CARE

PATIENT INFORMATION SHEET

Date:_____Referred By:_____Patient's Name: _____SSN:_____ Birthdate:_____

Age:____Address: _____ C/S/Z:_____Sex: M F Marital Status: M S W D

Phone #:_____ No. of Dependents: ____Occupation:_____ Employer:_____ Phone:_____

Student? F/T P/T Name of School :_____ Emergency Contact Person:_____

Employer:_____ Phone:_____ Relationship:_____ Address:_____

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT

Name of Responsible Person:_____ Relationship: _____Hm. Phone #:_____

Residence Address:_____C/S/Z:_____SSN:_____Employer:_____

# of Years Employed: _____Employer's Address:_____C/S/Z:_____

Wk. Phone #:_____ Dental Insurance:_____

IF DENTAL INSURANCE WILL BE INVOLVED, PLEASE COMPLETE INFORMATION BELOW:

PRIMARY INSURANCE

Insured's Name:_____ SSN:_____ Employer:_____Phone#: _____

Patient's Relationship to Insured: Self:_____ Spouse:_____Child:_____ Other:_____

Insurance Company:_____Group # :_____ Claims Address:_____

SECONDARY INSURANCE

Insured's Name:_____ SSN:_____ Employer:_____Phone #:_____

Patient's Relationship to Insured: Self:___ Spouse:___ Child:____Other:____

Insurance Company:_____ Group # :_____ Claims Address:_____

I authorize Dr. Neville and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name:_____Signature:_____Date:_____
(Patient, legal guardian or authorized agent of patient)

Witness:_____ Date:_____

Patient Name: _____ **Date of Birth:**_____

Who was your previous Dentist?:_____

So that we can better assist you with your dental concerns, please list in order of importance what is essential to you.

Please mark 1-3, with 1 Being most important item.

___ Health preservation/keeping your teeth for life, eliminate disease
___ Comfort and function/eating what you want to eat
___ Esthetics/how your smile looks

If you have had dental treatment recommended in the past and did not proceed, what factors prevented you from scheduling? (Here or somewhere else)

___ Cost
___ Fear of pain
___ No time
___ No insurance
___ Didn't hurt/ Didn't think I needed treatment
___ Other(Please explain)_____

HEALTH HISTORY

Do you require antibiotic pre-medication for a heart condition, artificial valve or artificial joint? Y / N
Do you bleed or bruise easily? Y / N
Do you have or have you ever had bleeding or sensitive gums? Y / N
Do you think that your teeth are affecting your general health in any way? Y / N

Check if you have or have had any of the following:

___ AIDS
___ Anemia
___ Arthritis
___ Artificial Heart Valve
___ Asthma
___ Back Problems
___ Cancer
___ Chemical Depend.
___ Circulatory Problems
___ Cortisone Treatments
___COPD
___ Congenital Heart
___ Dizziness
___ Diabetes
___ Down Syndrome
___ Epilepsy
___ Fainting
___ Glaucoma
___ Headaches
___ Heart Attack
___ Hear Murmur
___ Hepatitis, Type____
___Herpes
___High Blood Pressure
___ HIV Positive
___ Immune Disorder
___ Jaundice
___ Kidney Disease
___ Liver Disease
___ Lupus
___ Major Surgery, Type _____
___ Mitral Valve Prolapse
___ Mental Disorders
___ Nervous Disorders
___ Pacemaker
___Pregnancy?
Due Date:_____
___ Psychiatric Care
___ Radiation Treatment
___ Respiratory Problems
___ Rheumatic/Scar Fever
___ Sinus Problems
___ Skin Rash
___ Stroke
___Taking Phen-Fen
___ Thyroid Problems
___ Tobacco Habit
How Much?_____
Type: _____
___ Tuberculosis
___ Ulcers

Medications

List medications you are currently taking(Include oral contraceptives and alternative medicines)

_____

_____

Have you ever taken or are you on a Bisphosphate such a Fosamax, Boniva or any other drug prescribed to decrease the resorption of bone as in osteoporosis or any drugs for metastatic bone cancer? Y / N If yes, what and date of use:

_____

Allergies

___ Aspirin
___ Barbiturates
___Codeine
___ Latex
___ Local Anesthetic
___ Penicillin
___ Sulfa
___ Acetaminophen
___ Ibuprofen
___ Other_____

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE OF MY ABILITY. SINCE A CHANGE IN MY MEDICAL CONDITION OR IN MEDICATIONS I TAKE CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE RESPONSIBILITY TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT.

Signature_____ **Date**_____

(Patient, legal guardian or authorized agent of patient)

OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A monthly service charge at a fixed rate of 1.5% per month/18% per annum* of the unpaid balance as of the last day of each month will be assessed and added to the balance on all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination.

In consideration for the professional services to be rendered to me, (or at my request, to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or licensed employee at the time the services are rendered, or within five (5) days of billing if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection fee charged by the collection agency to whom a delinquent account is assigned for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have received a copy of this office's Privacy Policies and Financial Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

_____ _____

Signature of Patient, parent or guardian Date

Relationship to Patient_____

(Rev.4/10)