Adult Medical History

FORESTVILLE DENTAL

PATIENT FULL NAME_____ **DATE OF BIRTH**_____**CELL**_____

NAME OF FAMILY MEDICAL PHYSICIAN_____ **DATE OF LAST MEDICAL EXAM**_____

DO YOU HAVE OR HAVE EVER HAD?

☐ Abnormal Bleeding	☐ Emphysema	☐ Jaundice	☐ Respiratory Problems
☐ AIDS or HIV	☐ Epilepsy/Convulsions	☐ Jaw Pain	☐ Seizures
☐ Anemia	☐ Fainting/Dizziness	☐ Kidney Disease	☐ Sexually Transmitted Diseases
☐ Angina	☐ Glaucoma	☐ Leukemia	☐ Stomach Trouble/Ulcer
☐ Arthritis	☐ Hay Fever/Allergies	☐ Liver Disease	☐ Stroke
☐ Artificial/Damaged Heart Valves	☐ Heart Attack	☐ Low Blood Pressure	☐ Swollen Ankles
☐ Asthma	☐ Heart Disease	☐ Mitral Valve Prolapse	☐ Thyroid Problems
☐ Cancer	☐ Heart Murmur	☐ Osteoporosis	☐ Tuberculosis
☐ Cardiac Pacemaker	☐ Heart Trouble	☐ Radiation Therapy	OTHER:_____
☐ Chest Pains	☐ Hemophilia	☐ Rheumatic Fever	_____
☐ Diabetes	☐ Hepatitis A B C	☐ Rheumatism	_____
☐ Easily Winded	☐ High Blood Pressure	☐ Recent Weight Loss	_____

ARE YOU UNDER MEDICAL TREATMENT NOW?.....Y N EXPLAIN_____

ARE YOU CURRENTLY TAKING PRESCRIPTION MEDICATIONS.....Y N

PLEASE LIST _____

HAVE YOU BEEN HOSPITALIZED FOR ANY SURGICAL OPERATIONS OR SERIOUS ILLNESSES WITHIN THE LAST 5 YEARS?

EXPLAIN_____

HAVE YOU HAD A JOINT REPLACEMENT OR IMPLANT?.....Y N

IF SO, WHEN?_____

DO YOU USE ALCOHOL?.....Y N

IF SO, HOW MANY TIMES PER DAY?_____

DO YOU USE TOBACCO PRODUCTS?.....Y N

IF SO, HOW MANY TIMES PER DAY? _____

DO YOU USE RECREATIONAL DRUGS?.....Y N

IF SO, HOW MAY TIMES PER DAY?_____

ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

ANTIBIOTICS (I.E. SULFA DRUGS)……..Y N

PLEASE LIST_____

ASPIRIN……..……...Y N

IODINE……..……Y N

LATEX/RUBBER……..…….Y N

LOCAL ANESTHETIC (I.E. NOVOCAINE)……..……...……Y N

PLEASE LIST_____

SEDATIVES……..……..Y N

OTHER ALLERGIES PLEASE LIST _____

WOMEN ONLY:

ARE YOU PREGNANT OR THINK YOU MAY BE…….Y N

ARE YOU TAKING ORAL CONTRACEPTIVES…….Y N

ARE YOU NURSING……..…..…….……..Y N

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and /or health practitioners. I agree to notify the office of any health changes that may occur during the year.

_____ _____

SIGNATURE ***DATE***

Dental History

FORESTVILLE DENTAL

NAME_____ **DATE OF BIRTH**_____

DATE OF LAST DENTAL CLEANING & EXAMINATION?_____**X-RAYS**_____

WHY HAVE YOU COME TO THE DENTIST TODAY?_____

DO YOU REQUIRE ANTIBIOTICS BEFORE DENTAL TREATMENT?.....Y N

IF YES, FOR WHAT?_____

ARE YOU CURRENTLY IN PAIN?.....Y N

HAVE YOU EVER HAD A SERIOUS / DIFFICULT PROBLEM ASSOCIATED WITH ANY PREVIOUS DENTAL WORK?.....Y N

HAVE YOU EVER HAD GUM TREATMENT?.....Y N

DO YOU NOW OR HAVE YOU EVER EXPERIENCED PAIN / DISCOMFORT IN YOUR JAW JOINT (TMJ / TMD)?.....Y N

HOW WOULD YOU RATE YOUR CURRENT DENTAL HEALTH IS: GOOD FAIR POOR

IS THERE ANYTHING YOU WOULD LIKE TO CHANGE ABOUT YOUR SMILE?.....Y N

EXPLAIN_____

DO YOUR GUMS BLEED?.....Y N

HOW MANY TIMES A WEEK DO YOU FLOSS?_____ **HOW MANY TIMES A DAY DO YOU BRUSH?**_____

TYPE OF BRISTLES? SOFT MEDIUM HARD

HOW LONG DO YOU USE A TOOTHBRUSH BEFORE REPLACING IT?_____

ARE YOUR TEETH SENSITIVE TO HEAT, COLD, OR ANYTHING ELSE?_____

HAVE YOU LOST ANY TEETH? YES NO **IF YES, WHY?**_____

ADDITIONAL COMMENTS:_____

_____

_____

_____ _____

SIGNATURE ***DATE***

Forestville Dental, 7535 State Road Unit M, Cincinnati, Ohio 45255 (P) 513-231-5444 (F) 513-231-8135

FORESTVILLE DENTAL

Patient Consent

I understand that I have certain rights to privacy regarding my protected health information.
These rights are given to me under the Health Insurance Portability and accountability Act of 1996 (HIPAA).
I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

*** Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);**
*** Obtaining payment from third party payers (e.g. my insurance company);**
*** The day-to-day healthcare operations of our practice.**

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA.
I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operation, but that you are not required to agree to these requested restrictions.
However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time.
However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____day of _____, 20_____.

Print Patient Name_____ Signature:_____

Relationship to Patient:_____

Office Policies

for

Forestville Dental, Michael D. Farmer, D.M.D. Inc.

We are delighted to welcome you to our practice and are pleased that you chose us to serve your dental needs. We are serious about providing superior dental care at reasonable prices, and proud of our dedication to our patients. Our goal is to help you feel and look your very best through excellent dental care.

Please take a moment to review our office and financial policies.

Appointments

Upon arrival, please sign in and let the receptionist know you are here. Please update any changes in your address, phone numbers, or insurance information.

We confirm appointments as a courtesy to our patients, 48 hours prior to the appointment. We ask that you also give us ***48 hours notice*** if you need to change your appointment.

Late arrivals of greater then 10 minutes may be asked to reschedule their appointment(s).

All minors must be accompanied by a parent or guardian as we need your permission to treat them.

In order to complete a thorough examination, diagnosis and treatment plan current x-rays are necessary. Patient is responsible for providing a copy of bitewing x-rays (less than one year old) and a panorex (less than five years old). If copies are not provided patient may be financially responsible for the cost of new x-rays.

Missed appointments or no show appointments will be charged a $50.00 fee.

Insurance

I authorize and request my insurance company to pay directly to Forestville Dental, Michael D. Farmer, D.M.D., Inc.

As a courtesy to our patients, we do file your insurance for you. However, it must be stressed that ***your insurance is a contract between you, your employer and the insurance company***. We will do our best to help you receive your maximum benefits, we will not become involved in disputes between you and your insurance company regarding covered charges, secondary insurance, reasonable and customary determinations, etc.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Treatment Plans

An estimate will be provided for all treatment plans.

For patients who have insurance, an ***ESTIMATE*** will be given of the benefits that the insurance company is expected to pay. Any co-payment is expected at the time services are rendered.

Treatment plans are subject to change. In the event of any changes patient will be advised.

Payment Options

We accept Cash, Check, MasterCard, Visa, Discover. We also accept Care Credit. Please ask our staff for information on this dental finance program. The application process only takes a few minutes.

_____ _____

SIGNATURE OF PATIENT (or parent if minor) ***DATE***

Patient Information

FULL NAME_____**(PEFERRED NAME)**_____**M F**

ADDRESS_____**CITY**_____**STATE**_____**ZIP**_____

HOME PHONE_____**WORK**_____**EXT**_____**CELL**_____

SS #_____**DATE OF BIRTH**_____ **CIRCLE ONE:** MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

EMPLOYED BY_____**OCCUPATION**_____

IF COLLEGE STUDENT, NAME OF SCHOOL_____**CITY**_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

EMERGENCY CONTACT_____**RELATIONSHIP**_____**PHONE #**_____

Spouse Information

SPOUSE FULL NAME_____**BIRTHDATE**_____**SOCIAL SECURITY #**_____

SPOUSE EMPLOYER_____**OCCUPATION**_____**WORK PHONE**_____

Responsible Party

PERSON RESPONSIBLE FOR THIS ACCOUNT_____**RELATIONSHIP TO PATIENT**_____

ADDRESS_____**CITY**_____**STATE**_____**ZIP**_____

HOME PHONE_____**WORK**_____**EXT**_____**CELL**_____

Dental Insurance

NAME OF INSURED_____**RELATIONSHIP TO PATIENT**_____

SOCIAL SECURITY#_____**DATE OF BIRTH**_____**DATE EMPLOYED**_____

EMPLOYED BY_____**OCCUPATION**_____

EMPLOYER ADDRESS_____**CITY**_____**STATE**_____

INSURANCE COMPANY_____**GROUP #**_____**POLICY #**_____

INSURANCE ADDRESS_____ **CITY**_____**STATE**_____**ZIP**_____

Additional Dental Insurance

NAME OF INSURED_____**RELATIONSHIP TO PATIENT**_____

SOCIAL SECURITY#_____**DATE OF BIRTH**_____**DATE EMPLOYED**_____

EMPLOYED BY_____**OCCUPATION**_____

EMPLOYER ADDRESS_____**CITY**_____**STATE**_____

INSURANCE COMPANY_____**GROUP #**_____**POLICY #**_____

INSURANCE ADDRESS_____ **CITY**_____**STATE**_____**ZIP**_____

_____ _____

SIGNATURE OF PATIENT (OR PARENT IF MINOR) ***DATE***