Durell Family Dentistry

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Chart#_____

Name_____Soc. Sec. #_____
Last Name First Name Middle

Address_____City_____ State_____Zip_____

Home Phone_____Work Phone_____

Cell#_____Pager#_____E-mail Address_____

Sex ☐ M ☐ F Age_____D.O.B._____ ☐ Single ☐ Married ☐ Separated ☐ Divorced

Patient Employed By_____Occupation_____How long there_____

Employer Address_____City_____ State_____Zip_____

Whom May We Thank For ReferringYou? _____

Notify in Case of Emergency_____ Relationship_____Phone#_____

Primary Insurance Information

Person Responsible for Account_____
Last Name First Name Middle

Relationship to Patient_____D.O.B._____Soc. Sec.#_____

Address (if different from patients) _____ City_____State_____Zip_____

Home Phone_____Work Phone_____

Person Responsible Employed By_____Occupation_____

Insurance Company_____Group#_____ID#_____

Insurance Address_____Phone#_____

Name of Other Dependants Under This Plan_____

OVER

Additional Insurance Information

Is patient covered by additional insurance? ☐ **Yes** ☐ **No**

Subscriber Name_____
Last Name **First Name** **Middle**

Relationship to Patient_____ **Subscriber D.O.B**_____**Soc. Sec. #**_____

Address (if different from patients)_____**City**_____**State**_____**Zip**_____

Home Phone_____**Work Phone**_____

Subscriber Employed By_____**Occupation**_____

Insurance Company_____ **Group#**_____**ID#**_____

Insurance Address_____**Phone #**_____

Name of Other Dependants Under This Plan_____

As a courtesy to you, we will submit charges directly to your insurance company. Please be sure to provide us with accurate insurance information, as our office charges a $5.00 re-filing fee for claims that go unpaid over 90 days, due to inaccurate insurance information.

All accounts over 30 days are subject to a monthly 1.5% service charge (18 % annual). In the event, legal action is required to collect upon any unpaid balance that is due, all collection fees including attorney fees, will be paid by the patient.

There will be a $35.00 charge for all failed or missed appointments without 24 hours notice.

I authorize the insurance company indicated on this form to pay to the dentist, all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I further authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all fees charged by this office regardless of my insurance coverage, and that I am expected to pay my portion at the time of service, unless prior arrangements have been made.

_____ _____
Date **Signature of Patient, Parent or Guardian**

Dental History

Reason for visit today?_____**Are you having discomfort today?**_____

Date of last dental visit_____**Date of last dental x-rays**_____

FormerDentist_____**Address**_____**Phone#**_____

Please check if you have or have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Cold sores
- ☐ Grinding or clenching teeth
- ☐ Injury to face or jaw
- ☐ Loose teeth or broken fillings
- ☐ Orthodontic Treatment
- ☐ Periodontal treatment
- ☐ TMJ
- ☐ Sensitivity to hot/cold
- ☐ Sensitivity when biting
- ☐ Reaction to anesthetic
- ☐ Unusual/Prolonged bleeding
- ☐ Teeth Extracted

Any complications from prior dental work? ☐ **Y** ☐ **N If Yes explain**_____

_____

Are you nervous about having dental work performed?_____

How often do you brush? _____**Floss?**_____

Other information regarding your dental health or past dental treatment you would like us to know?_____

_____

Medical History

Physician's name _____ **Phone #**_____

Address_____**Date of Last Visit**_____

Are you currently under the care of a physician? ☐ **Y** ☐ **N** **If yes explain**_____

_____

Please check if you currently have or have had any of the following:

- ☐ Aids/HIV Positive
- ☐ Anemia
- ☐ Arthritis/Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer (type_____)
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Headaches
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Condition
- ☐ Hemophilia
- ☐ Herpes
- ☐ Hepatitis A B C
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Condition
- ☐ Pacemaker/Heart Surgery
- ☐ Psychiatric Treatment
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic/Scarlet Fever
- ☐ Shingles
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Ankles
- ☐ Thyroid Disease
- ☐ Tobacco Habit
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

OVER

If you have any medical condition not mentioned above please list_____

_____

List any medications you are currently taking:_____

_____

List any medications that you have an allergy to: _____

_____

Women:

Are you pregnant? ☐ **Y** ☐ **N** **If yes how far along?**_____ **Are you currently nursing?** ☐ **Y** ☐ **N**

Are you currently taking oral contraceptives? ☐ **Y** ☐ **N**

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate dental treatment.

_____ _____

Date **Signature of Patient, Parent or Guardian**

Finance Guidelines

Durell Family Dentistry

AS OF JANUARY 1, 2016

We are committed to providing you with the best possible care. In our office, we do not want money to be an issue for our patients. We want you to feel comfortable with us, and that includes feeling satisfied with your financial arrangement regarding your dentistry. We encourage you to enter into a financial arrangement that is comfortable for you. The following information is provided to ensure that each patient understands their financial responsibility prior to seeking treatment at Durell Family Dentistry.

1. We accept your insurance and will gladly file the claims as a courtesy to you. We are not a restricted provider, corporate or network dental office. We are a private practice. This means we are not bound by any limitations set by your insurance company. We base your treatment on what the doctors deem necessary for you and never on your insurance plan. We will help in every way possible to maximize your insurance with all of them. We ask that you become very comfortable with your plan and limitations.
2. We accept cash, money orders, checks and all major credit cards. Care Credit financing is available upon approval.
3. A deposit may be requested to hold your appointment time for you.

For your ease and convenience, we offer several types of financial arrangements:

1. A 5% immediate payment courtesy may be given when patient portion is paid in full with cash or check.
2. Payment may be divided into 2 equal payments for our patients of good standing record. Half at time of scheduling and half at appointment.
3. Comfortable monthly payments may be made through our billing company, CareCredit.

DENTAL INSURANCE

I understand my dental insurance is a contract between the insurance carrier and me, not between Durell & Durell Family Dentistry and the insurance carrier. Therefore, I am responsible for all dental fees. I understand I will be charged for all dental treatment and that any payments received by Dr. Durell from my insurance carrier will either be credited to my account or refunded to me if I have paid the dental fees incurred. Any fees not paid by my insurance 60 days after treatment are my responsibility.

_____ _____ _____

Patient Signature Date Financial Coordinator