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_____ Apt. ___ 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#_____

How would you like to be contacted about future appointments? ☐Text ☐ Email ☐ Phone Call ☐Postcard

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.

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.

I hearby acknowledge that a copy of the office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask qany questions I may have regarding this Notice.

_____ _____

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**_____ **Former Dentist**_____**Address**_____**Phone#**_____

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

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

_____

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

Durell _Durell Medical History

Patient Name: Birth Date: Date Created:

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.

Are you under a physician's care now?	Yes No	If yes	
Have you ever been hospitalized or had a major operation?	Yes No	If yes	
Have you ever had a serious head or neck injury?	Yes No	If yes	
Are you taking any medications, pills, or drugs?	Yes No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes	
Are you on a special diet?	Yes No		
Do you use tobacco?	Yes No		

Women: Are you...

- Pregnant/Trying to get pregnant?
- Nursing?
- Taking oral contraceptives?

Are you allergic to any of the following?

- Aspirin
- Penicillin
- Codeine
- Acrylic
- Metal
- Latex
- Sulfa Drugs
- Local Anesthetics

Do you use controlled substances?	Yes No	If yes	
Other?		If yes	

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

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

Have you ever had any serious illness not listed above?	Yes No	If yes	

Comments:

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:

X Date:_____

Durell Family Dentistry
Finance Guidelines

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. 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 limitation 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 benefits and any limitations.
2. Patients are responsible for their portion of payment the day services are rendered.
3. We require any outstanding balances to be paid in full before beginning any new treatment.
4. We accept cash, check, money orders and all major Credit Cards. Care Credit financing is available upon approval.
5. As dental professionals, with more than 20 years' experience, we deal ethically and honestly with every insurance provider and with every service claim we file. We will submit only for services rendered, specifically as they are rendered with the appropriate diagnosis.

It is our sincere desire to develop and maintain a strong relationship with each one of our patients. Feel free to contact to answer any further questions you may have regarding financial issues or insurance concerns.

I have read and fully understand the financial policy listed above..

_____ _____

Patient Signature Date

Durell & Durell DDS PC

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
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other(Please Specify)

_____

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