Terra Nova Family Dentistry

Patient History Form

Patient Information

Patient Name: ____ Date: ______________
Last, First MI (Preferred Name)

Birth Date: ____________ Social Security #: ____________________ Gender: _____________

Phone (Home): ____________________ (Work): ____________________ (Cell): ____________________

Address: ____
Street Apartment #

____
City State Zip Code

E-Mail Address: _________________________________ Referred By: _______________________

Health Information

Please Circle ***Yes*** *or* ***No*** *on each Box individually:*

Y N Anemia/ Blood Disease
Y N Arthritis
Y N Asthma
Y N Blood Pressure/ High
Y N Blood Pressure/ Low
Y N Cancer/TX/X-ray
Y N Diabetes
Y N Epilepsy/ Seizures
Y N Fainting /Nervous
Y N Glaucoma
Y N Heart Trouble
Y N Pace Maker

Y N Herpes Virus
Y N HIV Positive/ AIDS
Y N Joint Replacement
Y N Migraine Headaches
Y N Mitral Valve Prolepse
Y N Neck/ Head Pain
Y N Pregnant
Y N Rheum Fever/ Murmur
Y N Stroke
Y N TB/ Lung Disease
Y N TMJ/ Clicking Join
Y N Venereal Disease

Allergies:
Y N Aspirin
Y N Codeine
Y N Local Anesthesia
Y N Penicillin
Y N Sadat/ Tranq
Y N Premedicate
Y N Medical Alert
Y N Other
____
____
Y N Hepatitis/ Liver Disease

Signature: _________________

Name of My Physician: _________________________ Phone Number _________________________

Taking Medications Y N If yes, ____

What is your main concern with your teeth and mouth? ____

Health History Update:

Changes: ____________ Patient/Parent/ Guardian Signature: _______________________ Date:________

Changes: ____________ Patient/Parent/ Guardian Signature: _______________________ Date:________

Changes: ____________ Patient/Parent/ Guardian Signature: _______________________ Date:________

Spouse or Responsible Party Information

Name: ____ Relationship to Patient: _____________
Last, First MI

Birth Date: _____________ Social Security #: ______________________ Gender: ______________

Phone (Home): ______________________ (Work): ______________________ (Cell): ______________________

Address: ____
Street Apartment #

____
City State Zip Code

Employment Information

Employer Name: _____________________________________ Occupation: __________________________

Address: ____
Street

____
City State Zip Code

Insurance(s) Information

Primary:

Subscriber Name: _____________________________________ Relationship to Patient: _____________
Last, First MI

Sub. Birth Date: _____________ Sub. ID #: ______________________ Group #: ____________________

Insurance Name: ______________________________________ Phone #: ____________________________

Sub. Employer Name: __________________________________ Phone #: ____________________________

Secondary:

Subscriber Name: _____________________________________ Relationship to Patient: _____________
Last, First MI

Sub. Birth Date: _____________ Sub. ID #: ______________________ Group #: ____________________

Insurance Name: ______________________________________ Phone #: ____________________________

Sub. Employer Name: __________________________________ Phone #: ____________________________

Charges not covered by my dental insurance. I also agree to pay my co-payment at the time services are rendered.

____ _____________ ____________________________
Signature of Patient, Parent or Guardian Date Relationship to Patient

Patient Consent to Treatment

- In reading and signing this form it is understood that English is the language that I understand and use to communicate (initials)________

- ***Drugs Medications and Anesthesia:*** In understand that antibiotics ,analgesics and other medications may cause adverse reactions, some of which are, but are not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest.

  I understand that medications, drugs and anesthetics may cause drowsiness and lack of coordination increased by the use of alcohol or other drugs. I have been advised not to consume alcohol, nor operate any vehicle of hazardous device while taking medications and/or drugs, or until fully recovered from their effects (this includes a period of at least 24 hours after my release from surgery.)

  I understand that occasionally, upon injection of a local anesthetic, I may have prolonged, persistent anesthesia, numbness and or irritation to the area of injection.

  I understand that if I select to utilize nitrous oxide or any other sedative, possible risks include, but are not limited to, loss of consciousness, obstruction of airway, anaphylactic shock, cardiac arrest. I understand that someone needs to drive me home from the dental office after I have received sedation. I also understand that someone needs to watch me closely for a period of 8-10 hours following my dental appointment, to observe for possible deleterious side effects, such as obstruction of airway.

  (Initials) ________

- ***Hygiene and Periodontics (Tissue and Bone Loss):*** I understand that the long term success of treatment and status of my oral condition depends on my efforts and proper oral hygiene (i.e. brushing and flossing) and maintaining regular recall visits.

  Periodontics – I understand that I have a serious condition causing gum and bone inflammation and or loss, and that it can lead to loss of my teeth and other complications. The various treatment plans have been explained to me, including gum surgery, replacements and /or extraction. I also understand that although these treatments have a high degree of success, they cannot be guaranteed, occasionally, treated teeth may require extraction.

  (Initials) _________

- ***Dental x-rays:*** X-rays allow the dentist to diagnose and treat conditions that cannot be detected during a clinical examination. Dental x-ray films detect much more than cavities. For example, x-rays may be needed to survey erupting teeth, diagnose bone diseases, evaluate the results of an injury, or plan orthodontic treatment.

  If dental problems are found and treated early, before they become visible or painful, dental care is much more comfortable and affordable. Dental x-rays are a part of a comprehensive oral examination. However, your dental insurance may not cover the fee for x-rays.

  I have requested that no dental x-rays be taken today. I understand that some dental pathology cannot be diagnosed without the use of dental x-rays. I hereby release Terra Family Dentistry Inc. from responsibility for any oral conditions possibly present of which go undiagnosed as a result of my request that no dental x-rays be made.

  (Initials) _________

- ***DENTAL MATERIAL FACT SHEET***

I have received a copy of the dental material sheet. (initials) _________

TREATMENT PLAN RISK, BENEFIT AND ALTERNATIVE OR PROCEDURES WERE EXPLAINED TO ME .

(initials)_________

I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT THE PRPOSED TREATMENT WILL BE CURATIVE AND/OR SUCCESFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HER/HIS CARE, REALIZING THAT ANY LACK OF SAME COULD RESULT IN LESS THAN OPTIMUM RESULTS.

I CERTIFY THAT I HAVE HAD AN OPPOURTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE. INCLUDING THE OPPOSING SIDE OF THIS DOCUMENT, AND CONSENT TO THE OPERATION AND EXPLANATION REDERRED TO OR MADE I HAVE BEEN ENCOURAGE TO ASK QUESTIONS, AND HAVE HAD THEM ANSWERED TO MY SATISFACTION.

Signature: __________________________ Relationship ______________ Date:_____/______/_______

Doctor: _____________________________Witness:_________________

I Hereby authorize to Robert E. Maroon D.D.S of the dental benefits otherwise payable to me/

Signature __________________________ Date: ______/_______/_________

Terra Nova Family Dentistry

Statement of Office Policy

In our continued commitment to provide the highest quality health care available to all our patients, and to have our services comfortably affordable, we have made changes in our office policy that will create the maximum flexibility for everyone.

Terra Nova Family Dentistry, Inc. requires payment at the time of beginning your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

1. **Payment Options:**
   You can choose from:
   - Cash, Check, Visa, Mastercard, American Express or Discover Card
   - Convenient Monthly Payment Plans from CareCredit or Other
     - Subject to Credit Approval
     - Allow you to pay over time
     - No annual fees or pre-payment penalties

Please note that Payment is expected ***the same day of your appointment, if co-payment applies to visit.***

Check the method of your payment: **_____CHECK_____CREDIT CARD_____FINANCIAL UPON CREDIT_____CASH**

2. **In-House Financing upon Approved Credit:** A credit history will be needed. 18% financing charge will be added to your charge, and an application must be approved before treatment has begun.
3. **Insurance Benefits:** For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. However, if we do not receive payment from your insurance carrier or they deny payment for services done. You will be responsible for ***ALL*** remaining balances.
4. **Monthly statements:** Will go out every month of current activity on your account, please call us if you have any questions a finance charge will be added to your account if past due 90 days.
5. **Missed Appointments:** A fee of $50 is charged for patients who miss or cancel more than 2 times within 6 months without 48-hour notice.
6. **Returned Check(s):** Terra Nova Family Dentistry, Inc. charges $75.00 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need. I have read over and agreed to all of the above terms:

____

Patient, Parent or Guardian Signature Date

____

Patient Name (Please Print) Date