PARKS FAMILY
DENTAL
SMILES THAT LAST A LIFETIME

Patient Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Soc Sec: _____

Home Phone: _____ Cell Phone: _____ Preferred Contact: _____

Email: _____

How did you hear about us?: _____

Primary Insurance Information

Insured Name: _____ Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Date of Birth: _____

Employer: _____ Ins. Company: _____

Emergency Contact Information

Name: _____ Relationship: _____

Phone Number: _____

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MEDICAL HISTORY

Name: _____ Birthdate: _____

Although dental personnel 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.

Please answer the following questions:

Are you under a physician's care now? _____
Have you ever been hospitalized or had a major operation? _____
Have you ever had a serious head or neck injury? _____
Are you taking any medications, pills, or drugs? _____
Do you use tobacco? _____
Do you use controlled substances?_____
When was the last time you were seen by a dentist? _____
Were you ever recommended to take a premedication before your dental visit?_____
Are you currently in dental pain or discomfort? _____
Please list all Medications: _____
_____
_____

Women: Are you...
Pregnant/Trying to get pregnant ? ☐ Nursing? ☐ Taking oral contraceptives? ☐

ALLERGIES
Are you allergic to any of the following?
Do you have any Allergies? YES ☐ NO ☐
Are you allergic to any of the following?
Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐
Local Anesthetics ☐ Other Allergies? _____

Having you ever had the following :
☐Artificial Heart Valve, Year _____
☐Artificial Joint, Year_____

☐ AIDS/HIV positive	☐ Alzheimer's Disease	☐ Anaphylaxis
☐ Anemia	☐ Angina	☐ Arthritis/gout
☐ Asthma	☐ Blood disease	☐ Blood Transfusion
☐ Breathing Problems	☐ Bruise Easily	☐ Cancer
☐ Chemotherapy	☐ Chest Pain	☐ Cold Sores/ Blisters
☐ Congenital Heart Disorder	☐ Convulsions	
☐ Cortisone Medicine	☐ Diabetes	☐ Drug Addiction
☐ Easily Winded	☐ Emphysema	☐ Epilepsy or Seizures
☐ Excessive Bleeding	☐ Excessive Thirst	☐ Fainting spells/Dizziness
☐ Frequent Headaches	☐ Frequent Diarrhea	☐ Frequent Cough
☐ Gastrointestinal Disease	☐ Glaucoma	☐ GE Reflux/Persistent Heartburn
☐ Heart Murmur	☐ Heart Pacemaker	☐ Heart Attack/Failure, Year_____
☐ Heart Trouble/Disease	☐ Hemophilia	☐ Hepatitis A
☐ Herpes	☐ Hepatitis B or C	☐ High Blood Pressure
☐ High Cholesterol	☐ Hives or Rash	☐ Hypoglycemia
☐ Irregular Heartbeat	☐ Kidney Problems	☐ Leukemia
☐ Liver Disease	☐ Low Blood Pressure	☐ Lung Disease
☐ Mental Health Disorder (anxiety/depression etc)		☐ Migraines
☐ Mitral Valve Prolapse	☐ Osteoporosis	☐ Pain in Jaw Joints
☐ Parathyroid Disease	☐ Psychiatric Care	☐ Recent Weight Loss
☐ Radiation Treatments	☐ Renal Dialysis	☐ Scarlet Fever
☐ Sickle Cell Disease	☐ Shingles	☐ Sinus Trouble
☐ Stomach/Intestinal Disease		☐ Stroke, Year_____
☐ Swelling of Limbs	☐ Thyroid Disease	☐ Tonsillitis
☐ Tuberculosis	☐ Tumors or Growths	☐ Ulcers

☐ Have you ever had any serious illness not listed above?

Please describe

_____

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:_____Date:_____

(Must be 19 to sign)

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DENTAL INSURANCE AND FINANCIAL AGREEMENT

Welcome to our office. We are honored that you have chosen us as you dental health care provider.

Quality dental care is a financial investment. If you have insurance benefits we will work with you to help you understand and maximize your coverage. Insurance companies and coverage can vary. Your contract for insurance benefits exists between you and your insurance carrier.

Please remember that you are ultimately responsible for your account with our office. .

1. We accept payment by cash, check, credit or debit card, CareCredit and Proceeds.
2. You may receive an estimate of your liability prior to any dental appointments so that you will be financially prepared. Please remember that regardless of insurance coverage you are responsible for your account.
3. If you have dental insurance we will be happy to file your claim(s) for you as a courtesy. If 100% of the charges are not covered you will be responsible for the remaining balance.
4. When treatment is rendered our staff will fully brief you on the costs and ask that your estimated co-payment and deductible be paid at the time of service. After receiving payment through your insurance. we will send a statement with any leftover balances due or credits. In the event that your insurance does not pay within 45 days we ask that you make payment in full and contact your insurance company
5. If you do not have insurance, your insurance pays you directly, or you have met your insurance benefit maximum; You are responsible for the payment of the account in full.

Thank you for reviewing our financial and insurance policy. We will make every effort to explain your costs to you before any treatment so we can avoid misunderstandings and focus on your dental health. If you have any questions please do not hesitate to ask.

X_____ X_____

Patient Signature Date

X_____

Printed Name

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