CONFIDENTIAL MEDICAL & DENTAL HISTORY FORM

Date: ____/____/___

PATIENT NAME (Last, First, Middle):_____TITLE_____

ADDRESS:_____CITY_____ ST____ ZIP _____

HOME PHONE: ( )_____-_____ WORK: ( ) _____-_____ CELL: ( )_____ -_____

BIRTH DATE ___/____/____ S.S.# ____/____/____ How did you hear about us?_____

SEX (PLEASE CIRCLE): M F MARITAL STATUS (CIRCLE ONE): Single, Married, Divorced Widowed

EMAIL:_____

MEDICAL ALERTS:_____

Date Of Last Physical Exam: ____/_____/_____ Date Of Last Dental Exam: ____/____/_____

1. Are you now or have you recently been under a physician's care? _____ Yes _____ No
   Reason:_____
2. Have you ever been a patient in a hospital or had any serious illness?
   Explain:_____

ALLERGIES

3.Are you allergic to or do you suffer ill effects from any of the following?

YES	NO		YES	NO		YES	NO	
___	___	Penicillin	___	___	Codeine	___	___	Dental Anesthesia
___	___	Erythromycin	___	___	Latex	___	___	Bleach

Please list any other allergies you may have:_____

_____

4. Check any of the following that you have had or suspected:

YES	NO		YES	NO		YES	NO	
___	___	Arthritis	___	___	Shortness of Breath	___	___	HIV or AIDS
___	___	Hepatitis or Jaundice	___	___	Liver Disease	___	___	Stroke
___	___	Anemia	___	___	Diabetes	___	___	Blood Disease
___	___	Rheumatic Fever	___	___	Glaucoma	___	___	Prosthetic Joint Replacement
___	___	Severe Heart Injury	___	___	Chest Pain	___	___	Sinus Trouble
___	___	Emphysema	___	___	Kidney/Bladder Trouble	___	___	Fainting Tendency
___	___	Heart Trouble	___	___	Radiation Treatment	___	___	Blood Transfusion
___	___	Cancer or Tumor	___	___	Venereal Disease	___	___	Epilepsy
___	___	Ulcers	___		Bleeding Problem	___	___	Thyroid Disease
___	___	Heart Murmur	___	___	Psychiatric Disorders	___	___	High/Low Blood Pressure(circle one)
___	___	Tuberculosis	___	___	Lung Disease			
			___	___	Asthma or Hay Fever			

5. Check any of the following that you are taking or have taken

YES	NO		YES	NO		YES	NO	
__	__	Steroids	___	___	Sedatives	___	___	Blood
___	__	Osteoporosis Medications						

6. Are you taking any other medication? ___ YES ___NO Please list: _____

7. Have you ever been asked to pre medicate before dental appointment for the following conditions? (Circle all apply):
   Cyanotic Congenital Heart Disease Cardia Transplant Artificial Heart Valves History of Infective Endocarditis
   Prosthetic Joint Replacement Other: _____

Women Only:

Are you pregnant?___ YES ___ NO If yes: How many months? _____ Are you breast feeding? _____

PLEASE NOTE: If you are taking any kind of birth control pills, shots or implants hormone therapy. etc.. please indicate these:_____

Global Family Dental

Financial Policy

At Global Family Dental we want to create health with our patients through a health care continuum model. This model promotes alignment of oral health with overall health for each patient. In doing so we are making every effort to keep the cost down for dental care. Please read the financial policy below to familiarize yourself with our payment procedures.

Patients that do not have dental insurance are expected to pay for treatment in full on the day it is received. Payment options include cash, credit card/ debit card or Lending Club/ Care Credit. Lending Club/ Care Credits is a program with flexible terms and reasonable monthly payments. You may learn more about Lending Club/ Care Credit by asking one of our team members or by visiting www.lendingclub.com/ and /or www.carecredit.com.

If you are fortunate to have dental insurance you should understand that your dental benefits are based upon a contract between your employer and an insurance company. If you have any questions regarding your dental benefits you should contact your employer or insurance company directly. Please note dental insurance typically does not cover 100% of the cost of treatment. Global Family Dental requires patient to pay for their portion of the treatment at the time of service. This portion is an estimate based on your insurance coverage and is not a guarantee. Should your insurance provider not cover the remaining portion of your bill in full you will be responsible for paying the remaining balance.

If we have not received the payment from your insurance provider within 30 days we will follow up on the status of your claim. If we still have not received payment or correspondence from your provider after 45 days we will contact you so you can follow up with your provider directly.

If an account is more than 90 days overdue a finance charge of 1.5 % will be assessed monthly to the balance on your account. Please note you will receive reminders prior to the 90 day threshold and after to ensure you are aware of the status of your account.

We reserve the right to send outstanding balances to collection after we have made reasonable attempts to resolve. Should your account be turned over to collections, you are responsible for all fees associated with collection on your account including but not limited to, collection agency fees and attorney fees.

By signing below you agree to all conditions listed above. We want you to be satisfied with your experiences here at Global Family Dental and encourage to ask any questions of our team.

Print Name:_____ Date:_____

Patient/ Caregiver Signature:_____

PATIENT CONSENT FORM (HIPAA)

Our notice of privacy practices provides information about how we may use and disclose Protected Health Information, (PHI), about you. The notice contains a Patients Right section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected the PHI about you is used or disclosed for treatment, payment and health care operation. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our policy of PHI. You have the right to revoke this consent signed, in writing, signed by you. However, such revocation shall not affect any disclosures we have made in reliance on your prior consent. We have provided this form to comply with the Health Insurance Portability and Accountability Act of 1996(HIPAA).

The patient understands that:

- Protected Health Information may be disclosed or used for treatment, payment or health care operation.
- The practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the use of his / her information but the Practice doesn't have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The practice may condition treatment upon the execution of this consent.

The consent was signed by: _____

(Patient's name and patient's or Representative or Guardians Signature)