MEDICAL HISTORY

Patient Name	Medical Alert

Welcome! Please complete the information below so we can provide you with the best possible care.
All information is completely confidential.

1. Have you been under the care of a medical doctor during the past two years? ..... Yes No
   If Yes, for what? _____
   Physician's Name _____ Phone _____
   Address _____ City _____ State _____ Zip _____

2. Please list all medications you are currently taking: _____
   _____

3. Have you ever taken prescription medications for weight loss (diet pills)? ..... Yes No
   If Yes, did you take any of the following?
   Fen-Phen (Fenfluramine-Phentermine) ..... Yes No
   Pondimen (Fenfluramine) ..... Yes No
   Redux (Dexfenfluramine) ..... Yes No
   If you answered Yes to any of the above, did you have a medical exam for heart issues? ..... Yes No

4. Are you aware of having an allergic (or adverse) reaction to any medication or substance? ..... Yes No
   If Yes, please list: _____

5. Have you been hospitalized during the past five years? ..... Yes No

6. Indicate which of the following you have had, or have at present. Circle either "Yes" or "No" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Hay Fever	Yes	No
Chest Pain	Yes	No	Latex Sensitivity	Yes	No
Congenital Heart Disease	Yes	No	Allergies or Hives	Yes	No
Heart Murmur	Yes	No	Radiation Therapy (Head or Neck)	Yes	No
High Blood Pressure	Yes	No	Chemotherapy	Yes	No
Mitral Valve Prolapse	Yes	No	Tumors	Yes	No
Artificial Heart Valve	Yes	No	Prolonged Bleeding	Yes	No
Heart Pacemaker	Yes	No	Venereal Disease	Yes	No
Rheumatic Fever	Yes	No	H.I.V.	Yes	No
Arthritis/Rheumatism	Yes	No	Cold Sores/Fever Blisters	Yes	No
Stroke	Yes	No	Liver Disease (Cirrhosis, Hepatitis, Jaundice)	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Lung Disease (Asthma, Emphysema, TB)	Yes	No
Kidney Disease	Yes	No	Neurological Disorders	Yes	No
Ulcers	Yes	No	Epilepsy or Seizures	Yes	No
Diabetes	Yes	No	Fainting or Dizzy Spells	Yes	No
Thyroid Problems	Yes	No	Nervousness/Anxiety	Yes	No
Glaucoma	Yes	No	Psychiatric/Psychological Care	Yes	No

7. Do you have—or have you had—any disease, condition, or problem not listed above? ..... Yes No
   If Yes, please list: _____

8. **Women.** Are you: **Pregnant?** Yes, ____ Months No **Nursing?** Yes No **Taking Birth Control Pills?** Yes No

I understand that the above information is necessary to provide dental care in a safe and efficient manner. I have answered all questions accurately to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review _____
_____
_____
_____

Dentist's Signature _____ Date _____

PATIENT REGISTRATION

1. PLEASE TELL US A BIT ABOUT YOURSELF. YOUR ANSWERS ARE COMPLETELY CONFIDENTIAL.

DATE		NAME (LAST, FIRST, M.I.)			PREFERS TO BE CALLED
COMPLETE ADDRESS (STREET, CITY, STATE, ZIP)					
HOME PHONE		CELL PHONE		E-MAIL	SOCIAL SECURITY NUMBER
BIRTHDATE	AGE	GENDER (CIRCLE ONE) MALE FEMALE		MARITAL STATUS (CIRCLE ONE) MARRIED SINGLE DIVORCED WIDOWED	
IS ANOTHER MEMBER OF YOUR FAMILY A PATIENT AT OUR OFFICE? IF SO, PLEASE INDICATE BELOW: NAME:				RELATIONSHIP:	
YOU WERE REFERRED TO US BY				HOW DID YOU HEAR ABOUT US?	
IN THE EVENT OF AN EMERGENCY, PLEASE CONTACT				TELEPHONE	RELATIONSHIP TO PATIENT
COMPLETE ADDRESS OF EMERGENCY CONTACT (STREET, CITY, STATE, ZIP)					
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT (IF NOT YOU)				RELATIONSHIP TO PATIENT	SOCIAL SECURITY NUMBER
COMPLETE ADDRESS OF FINANCIALLY RESPONSIBLE PARTY (STREET, CITY, STATE, ZIP)					

2. IF THIS APPOINTMENT IS FOR YOUR CHILD, PLEASE COMPLETE THIS SECTION. IF NOT, CONTINUE ON TO SECTION 3.

DATE		NAME (LAST, FIRST, M.I.)			PREFERS TO BE CALLED
COMPLETE ADDRESS (STREET, CITY, STATE, ZIP), IF DIFFERENT FROM ABOVE					
HOME PHONE		CELL PHONE		E-MAIL	SOCIAL SECURITY NUMBER
BIRTHDATE	AGE	GENDER (CIRCLE ONE) MALE FEMALE		SCHOOL	GRADE

3a. PRIMARY DENTAL INSURANCE CARRIER.

INSURANCE COMPANY	GROUP NUMBER
EMPLOYER NAME	INSURED'S NAME
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S IDENTIFICATION NO.	INSURED'S SOCIAL SECURITY NO.

3b. SECONDARY INSURANCE CARRIER (IF APPLICABLE).

INSURANCE COMPANY	GROUP NUMBER
EMPLOYER NAME	INSURED'S NAME
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S IDENTIFICATION NO.	INSURED'S SOCIAL SECURITY NO.

4. CONSENT FOR TREATMENT.

1. I hereby authorize Dr. Boardman or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by Dr. Boardman to make a thorough diagnosis of the above-named patient's dental needs. Upon such diagnosis, I authorize Dr. Boardman and/or her staff to perform all recommended treatment mutually agreed upon by me and to employ such assistance as is required in order to provide proper care.

2. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

3. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event that payments are not received by agreed-upon dates, I understand that charges may be applied to my account as outlined in a separate financial agreement. I also understand that, if required, a check of my credit history may be made.

Patient's Signature: _____ Date: _____ Witness: _____

Parent/Responsible Party's Signature: _____ Relationship to Patient: _____

REBECCA BOARDMAN, D.D.S.

COMPREHENSIVE RESTORATIVE DENTISTRY

OUR FINANCIAL POLICY

Uninsured Patients

For patients without dental insurance, or patients whose insurance benefit maximum has been met or exceeded for the contract year, full payment is due at time of service, including any past-due balance. We accept cash and checks, as well as Visa, Mastercard, Discover and American Express cards.

Insured Patients

For patients with active insurance coverage, we will submit your claim for services rendered, then bill you for any remaining balance your provider did not cover.

The remaining balance due after an insurance claim has been settled is your responsibility *whether your insurance company pays or not*. Some or even all of the services provided may be non-covered and not considered reasonable and necessary by your insurance company. Your insurance policy is a contract between you and your insurance provider, and reimbursement levels are dependent upon the premiums you pay, the benefits your company negotiates, and frequency limitations. We are not a party to that contract.

If your insurance company has not paid on a submitted claim within 60 days, you will be responsible for the total amount of your balance and it will become your responsibility to collect any unpaid benefit from your insurance company. Any amount insurance pays to our office that you have already paid will be refunded to you or, if you wish, will be credited to your account to be applied to future treatment.

Please note that, in order to bill your insurance company properly, we must have your complete and accurate insurance information and be kept up-to-date regarding any changes to this information.

Please note that any insurance benefit figure provided by our office is an *estimate* only. Contact your dental insurance provider with any questions regarding your coverage, and request a pre-treatment estimate of coverage before embarking on any potentially costly treatment.

Usual and Customary Rates

We charge what is usual and customary for prosthodontic practices in our area. You are responsible for payment regardless of what an insurance company may define as "usual and customary fees."

Missed Appointments

Because office time and materials are reserved for you, a fee may be assessed for a missed appointment not canceled at least 24 hours in advance. The first such fee will be $75.00; subsequent fees will be charged at our current hygiene rate. Please help us serve our patients efficiently by keeping your scheduled appointments or giving us as much advance notice as possible of a conflict in your schedule.

Delinquent Accounts

We appreciate payment within 30 days of billing statement receipt. Payments received later than 30 days are subject to a monthly 1.5% finance charge ($5.00 minimum). Accounts over 90 days past-due are subject to submission to a collection service, which may adversely affect your credit rating. We reserve this as a final collection measure after all other attempts have been exhausted.

Our practice is committed to providing the best possible dental and oral health care and making your visit with us as enjoyable as possible. Please feel free to discuss any questions or concerns you have regarding the above.

I have read, understand, and agree to this Financial Policy.

_____ _____

Signature of responsible party Date