MEDICAL HISTORY

PATIENT NAME ______________________________ Birth Date ______________________________

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, please explain: ______________

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ______________

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ______________

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ______________

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ______________

Are you on a special diet? ◯ Yes ◯ No ______________

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ 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 ☐ Local Anesthetics

☐ Other If yes, please explain: ______________

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

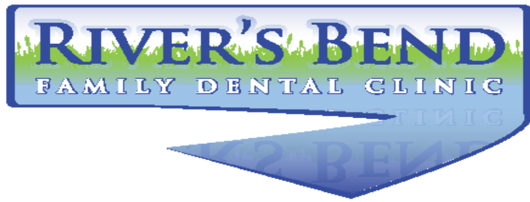
☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: ______________

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 ______________________________ DATE ______________



Dr. Otis D. Schultheis
14061 St. Francis Boulevard
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(763) 576-1855

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name ____

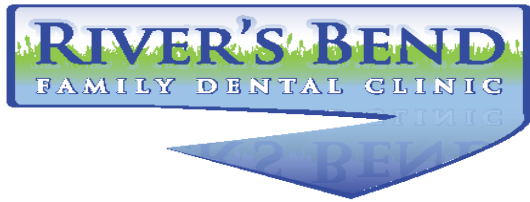
Relationship to Patient, *(If signing on behalf of a patient)* ______________________

Signature____Date____________

OFFICE USE ONLY

We attempted to obtain the Patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but were unable to do so as documented below:

Date____________ Initials__________ Reason__________________________________



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Patient Information

Patient Name____Birthdate__________
Last First Middle Initial

Home Phone____________________Cell Phone____________________________

Residence Address________________________City__________State____ Zip________

How long at present address?____

If Patient is a minor, parent or guardian's name______________________________

Employer________________ Address________________ Phone__________

Position____________________ How long at present employer?________________

Social Security Number__________________ Driver's License Number______________

Do you have dental insurance?____

If not, how do you intend to pay? _____Cash _____Check _____ Credit Card

*Current Credit Card Number____________________ Expiration Date________ ***(Required)**

Insurance Company Name and Address____

____

Subscriber____________________________ Policy Number______________________

Spouse's Name_________________________ Birthdate__________________________

Spouse's Social Security Number _______________ Spouse's Phone Number__________

Spouse's Employer and Address____

______________________________________Employer's Phone____________________

Secondary Insurance Name and Address______________________________________

____ Policy Number________________

Physician's Name____________________ City________________ Phone__________

Person financially responsible for this account________________________________

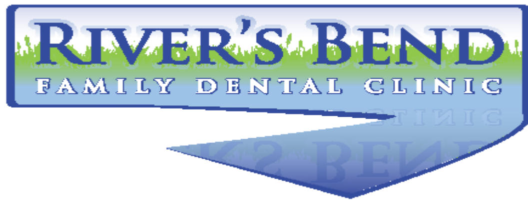
Nearest relative not residing with you_____________________________________

Relationship to Patient ________________________________Phone ______________

Whom may we thank for referring you?_____________________________________

In case of emergency, please contact _______________________Phone______________

Signature____________________________________ Date______________



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FINANCIAL POLICY

Welcome to River's Bend Family Dental Clinic! Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining important health treatment. Being sensitive to the fact that people have different needs in fulfilling their financial obligations, we are providing the payment options listed below:

☐ **Payment in Full (without insurance):**

- **Cash or Check** – A bookkeeping courtesy of 5% is given for payment in full at the time of treatment.
- **Credit Card** – We accept Visa, MasterCard, Discover and American Express.
  (The 5% bookkeeping courtesy does not apply.)

☐ **With Insurance**: Your out-of-pocket co-pay is due at the time of treatment. After your insurance claim has been processed, any remaining balance is due in full at that time.

☐ **Extended Payment Plan:**

- **Dental Fee Plans** – We offer the Care Credit payment plan to qualifying candidates with interest-free financing for up to18 months or a low monthly interest rate for extended payment plans.
  Please see our Office Manager for an application.
  (*Good credit standing required.*)

* ***For dental work over $200.00, a current credit card number and expiration date is required. We will not carry an account balance past 90 days.***

As a courtesy to our patients, all insurance forms will be filed on behalf of the patient by our office, free of charge. *Please be advised that regardless of your dental coverage, our Clinic relies on you for settling your account.*

We have eliminated costly bookkeeping and billing fees by implementing the above policy. The savings is reflected in our fee schedule, thus maintaining reasonable fees for our patients.

Broken Appointment Policy: There will be a $50 per appointment hour chair charge for failed appointments or appointments cancelled with a less than 24-hour notification.

I acknowledge that I have read with understanding and agree to the terms as stated above.

Signature____ Date:________________________