Modern Day Smiles
General, Cosmetic and Emergency Dentistry

Medical History Form

General Information
Name (First, M. Last): _____ Today's Date: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone #:_____ Work Phone #:_____Cell Phone #: _____
Email Address:_____ Date of Birth:_____
Social Security Number:_____ Drivers License Number:_____
Emergency Contact (Name/Relationship/Phone Number):_____

Dental Information (Yes/No & Details)
Main Reason for Today's Visit? _____
Who should we thank for your Referral? _____
Tooth Pain? _____ Jaw Pain (clicking/popping)? _____
Bleeding Gums? _____ Cold/Hot/Sweets/Pressure Sensitive teeth? _____
Mouth Dry/Sore? _____ Past "Deep Cleaning"/ Gum Treatments?_____
Grind your teeth? _____Snoring?_____
Last Dental Exam or Cleaning (Where & Date):_____

Medical Information (Primary Care, Internal or Family Medicine)
Physician Name: _____
Address: _____ City: _____ State:_____ Zip Code:_____
Phone: _____ Fax: _____ Email: _____
Are you in good health? _____ Last Checkup? _____
Any serious illness/conditions, operations or hospitalizations within last 5 years? (Date & Details)_____
_____
_____ _____
Medications? (List all names including vitamins)_____
_____
_____
_____

Medical Allergies (Yes/No & Details)
Local Anesthetic (Dental)?_____Penicillin (or any other antibiotics)?_____
Barbituates, Sleeping Pills, Sedatives?_____ Sulfa?_____
Codeine/Narcotics?_____ Metals?_____ Latex?_____
Certain Foods?_____ Seasonal Allergies?_____Other?_____
Details;_____

Medical Information (Yes/No & Details with Date of Treatment/Diagnosis)
Joint Replacement?_____ Artificial Heart Valve?_____
Heart Surgery/Pacemaker?_____ Heart Attack (Myocardial Infarction)?_____
Previous Infective Endocarditis?_____ Congenital Heart Disease?_____
Anemia/Abnormal bleeding?_____ High/Low Blood Pressure?_____
Diabetic (Type 1 or 2)?_____ Stroke?_____
Asthma?_____ COPD/Emphysema?_____
Osteoporosis?_____ Arthritis/Joint Pain?_____
Cancer/Chemotherapy? _____ Radiation? _____
Seizures/Epilepsy?_____ Swollen Glands?_____
Tobacco?_____ Any other controlled substances?_____
Diseases / Other Chronic Conditions (ie STDs, HIV/AIDS, GERD)?_____
Details:_____
(For Women)
Pregnant (If so, how many months)?_____ Nursing?_____

Please discuss any and all relevant patient health issues prior to treatment.
I acknowledge my questions and concerns have been answered and I have filled in this form truthfully and accurately.

Signature:_____Date:_____

Financial Information/Policy

Dental Insurance Information (Primary)	Dental Insurance Information (Secondary)
Policy Holder's Name: _____ Policy Holder's DOB: _____ Policy Holder's Employer: _____ Insurance Co Name: _____ Insurance Co Address: _____ Insurance Co Phone # _____ Policy Holder's SSN or ID# : _____ Group#:_____	Policy Holder's Name: _____ Policy Holder's DOB: _____ Policy Holder's Employer: _____ Insurance Co Name: _____ Insurance Co Address: _____ Insurance Co Phone#: _____ Policy Holder's SSN or ID#: _____ Group#: _____

FINANCIAL POLICY

The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, money orders, MasterCard, Visa, American Express and Discover. Outside financing is available upon request and approval. Drivers Licenses may be confirmed when paying by check.

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges which may be based on a percentage of up to 33% maximum of accounts balance.

• As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.

• All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company.

• You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

• We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.

• We ask that you pay the deductible and co-payment, at the time we provide the service to you.

• Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. **If payment is not received or your claim is denied, you will be ultimately responsible for paying the full balance amount.**

Appointment Policy: Appointments are reserved especially for you! A notice of at least 24 hours must be given for cancellation or rescheduling of appointments. A fee of a minimum of $50 and/or up to 100% of your scheduled appointment amount will be charged TO YOU, for last minute cancellations or "No Show" appointments.

Consent:

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MODERN DAY SMILES. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance.

By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose.

Signature: _____Date: _____

(For office use only)
