PATIENT'S INFORMATION

Please Print Clearly!

☐Mr. ☐Mrs. ☐ Ms. ☐Dr.

Patient Name:_____ **Date of Birth:**_____
(First) (M) (Last) (MM/DD/YYYY)

Mailing Address:_____
(Street) (City, State, Zip)

Home Ph #: (_____)_____ Work Ph#: (_____)_____ Cell Ph #: (_____)_____

Email:_____ Employer:_____

Emergency Contact: ☐Parent ☐Brother ☐Sister ☐Child ☐Wife ☐Husband ☐Partner ☐Friend

Name:_____ Phone: (_____) _____

MEDICAL UPDATE

At our **doctor's request** this is required at every check-up visit to insure we have the correct medical information.

1. Are you seeing a physician or have been hospitalized since your last visit? ☐Yes ☐No

If yes, please explain: _____

2. Are you taking any medications? ☐Yes ☐No ***we are happy to make a copy if you have a list***

Please list names and dosage: _____

3. Do you have any heart problems, had heart surgery, or have an artificial heart valve? ☐Yes ☐No

Explain: _____

4. Do you have any other medical problems? ☐Yes ☐No

Explain: _____

5. Are you allergic to any medications or materials such as latex? ☐Yes ☐No If yes, please list:

_____

6. Do you have any joint implants? ☐Yes ☐No If yes, list type and date of surgery:_____

7. Are you on chemotherapy or radiation treatment? ☐Yes ☐No
8. Do you smoke or use tobacco? ☐Yes ☐No
9. Do you take any anticoagulants or blood thinners? ☐Yes ☐No
10. Do you take any medications for osteoporosis or low bone density? ☐Yes ☐No

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Dental Insurance:_____ Date coverage started:_____

***Please supply a copy of your insurance card. If you have a digital copy, please email it to **valleyfamilydentistry1@gmail.com**

_____ **Date:**_____

Patient/Parent/Guardian Signature

Office Staff Initial

VALLEY FAMILY
DENTISTRY

Financial Assignment / Agreement and Policy:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

2. In the event your account becomes past due and we engage an attorney to collect the account, you agree to pay attorney fees in the amount of ⅓rd of the amount due to us and agree that this attorney fee is reasonable.

3. In order to control your cost of billing, we request that your portion for office visits be paid at the conclusion of each visit unless prior financial plans have been established.

4. **A finance charge will be added to accounts after 60 days at 18% annually**. In the event your account is sent to collections you will be responsible for all court costs, collection fees and attorney fees.

5. *Due to the high cost of overhead and high demand for appointments there may be a charge of $50 or more for broken appointments and appointments not cancelled 24 hours before the appointment time. Payment of these charges will be required before other appointments are scheduled.*

6. There will be a *$25 charge* for all returned checks.

7. State law requires blood testing of any patient if a dentist/employee is exposed to any body fluids that could cause risk of infection.

_____

*******Print Patient's Name*******

_____

*******Patient's Signature*******

_____

If minor, Parent or Guardian Signature

_____

*******Date*******