Welcome to Forest Family Dentistry

1045 Thomas Jefferson Rd. Forest, VA 24551

(P) 434-316-6050 (F) 434-316-6055

ForestFamilyDentistry@yahoo.com

• Personal Information

Name - _____ Email - _____

Address - _____

City - _____ State - _____ Zip - _____

Social Security Number - _____ Date of Birth - _____

Male Female Single Married Divorced Widowed Separated

Employer - _____ Occupation - _____

Referred by - _____

• Responsible Party (Who is responsible for the account?)

Same as above

Name - _____ Email - _____

Address - _____

City - _____ State - _____ Zip - _____

Social Security Number - _____ Date of Birth - _____

Cell Phone - _____ Home - _____ Work - _____

Employer - _____ Occupation - _____

• Telephone

Cell Phone - _____ Home - _____

Work - _____ Ext # - _____

Where do you prefer to receive calls? Home Work Cell

When is the best time to reach you? Time - _____ Days - _____

In the event of an emergency, who should we contact? _____

• Dental Insurance Information

Primary Insurance	Additional Insurance
Name of Insured - _____	Name of Insured - _____
Policy holder - _____	Policy holder - _____
Policy holder's birthdate - _____	Policy holder's birthdate - _____
Social Security Number - _____	Social Security Number - _____
Employer - _____	Employer - _____
Insurance Company - _____	Insurance Company - _____
Group Number - _____	Group Number - _____
I.D. Number - _____	I.D. Number - _____

• Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient/guardian if minor Date

• Financial Arrangements

For your convenience, we offer the following methods of payment.

Please check the option which you prefer. Payment in full is expected at each time of visit.

_____Cash _____Personal Check ____Credit Card _____Care Credit

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

All appointment changes or cancellations require 24 hour notice

****Any missed appointments will be assessed a $75.00 fee****

Forest Family Dentistry

Appointment/Cancellation/No Show Policy

Appointments

Office visits are by appointment only. Please call 434-316-6050 to schedule any appointments. So, that we may schedule your appointment efficiently, we may ask the reason for your visit. Please arrive 15 minutes early for your appointment and please bring a copy of your insurance information. Patients who are late for any appointment may be asked to reschedule. We strive to keep all scheduled appointments on time, with the exception of emergency treatment for another patient. Please bring a list of all prescriptions, over the counter medications, vitamins, and supplements to each office visit, so we may review and update your chart.

Cancellations

We value all of our patients and strive to provide the best dental care possible in the most comfortable setting. Please understand that when we schedule your appointment we are reserving that time for your particular needs. We kindly ask that if you must change your appointment to please give us at least 24 hour notice. This makes it possible to give your reserved time to another patient in need of dental care. We know your time is valuable. When an appointment is made a room is reserved for you, your records are prepared, and special instruments are readied for your visit. Except in the case of emergency treatment for another patient, you can expect us to be running on schedule.

Missed Appointments (No Shows)

We understand that the occasional missed appointments can occur for a variety of reasons. When you miss an appointment without cancelling 24 hours in advance someone else in need of dental care is delayed unnecessarily. A "No Show/Late Cancellation" is defined as : missing an appointment without cancelling at least 24 hours before your scheduled time. There will be a charge for a missed or non-cancelled appointments of $75. Insurance will not cover charges for no show/late cancellation fees. This charge is in addition to any other charges you may have incurred. No refunds will be given and reoccurring missed appointments may result in discharging you from the practice.

Financial Policy

We work with most dental insurances and will try to help you get the most out of your policy. We will file your insurance as a courtesy, but we do not know every patient's insurance limitations. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. We ask that you pay your estimated portion at each visit. In the event that a statement is necessary, there will be a $5 fee per statement. You can sign up for a free electronic statement at DentalBillPay.com if you wish to avoid this fee.

Online Enrollment ID 10160-Q685 Account # _____ Zip Code _____

A late charge of 1.5% will be incurred each month the entire balance is not paid. This balance is expected to be paid within 25 days of the statement date. I realize that failure to keep this account current may result our practice being unable to provide dental services. With the exception of dental emergencies or when there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

For your convenience we accept all major credit cards and participate with Care Credit.

_____ _____ _____

Print Patient Name Signature Date

Forest Family Dentistry

"HIPAA" 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 have received read and understand your *Notice Of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. 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 below to obtain a current copy of the *Notice of Private 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 health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

Patient Name - _____

OKAY to talk to - _____

Signature - _____

Date - _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date_____ Initials_____ Reason _____

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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, c

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	
Do you use controlled substances?	○ Yes ○ No	If yes

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	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

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

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medidne	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No
						Yellow Jaundice	○ Yes ○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes

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:

X Date:_____