Knox Village Dentistry & Orthodontics
Office 214.265.7771
Fax 214.559.7078

Medical History Form

Patient Information

Patient's Name: ____

Last First Middle Initial

Social Security ______________________ **Sex: M F Date of Birth** ____________________ **Age** ________

If the Patient is a Minor, give Parent's or Guardian's Name ________________________________

Email______________________ **Best number To Text you at?**______________________________

Responsible Party Information

Last Name ____________________ First ____________________ Middle __________ Marital Status ________
Address ______________________ City __________________ State ________________ Zip ________
Driver's License No. ________________ Home Phone ______________ Work Phone ____________________
Date of Birth ______________________ Relationship to Patient ______________________________
Employer ____________________ Occupation ____________________ No. of Years Employed ______________
Employer Address____
Name/Address/Phone No. of nearest relative not living with you ______________________________

How did you hear about us? Please check below:

☐ Yellow Pages ☐ Friend/Relative ☐ Radio Ad. – Which Station? _________ ☐ Bill Board
☐ Sign ☐ Mail Coupon ☐ News Paper – Which one? ___________ ☐ Employer
☐ Employee ☐ Health Fairs/Screenings ☐ Other (Specify) ______________________________

Reason for today's dental visit ____
Date of last dental visit ____________________ Reason ______________________________
Have you ever had an experience in a dental office, that you would like to tell us about? Yes No If Yes, please explain ____________________
____

Are you apprehensive about dental treatment? Yes No
Do your gums bleed, feel tender or irritated? Yes No
Are you now seeing a physician? Yes No
Are your teeth sensitive to hot, cold, sweets, pressure? Yes No
Do you have discolored teeth that bother you? Yes No
Are you unhappy with the appearance of your teeth? Yes No
If so, what is the condition being treated? ____
The Name & Address of my Physician (s) is ____
What medications are you taking now? ____
If female, are you pregnant? Yes No If Yes, how long? ________________________

Mark any of the following which you have had or have at present:

☐ Heart Disease	☐ Heart Pacemaker	☐ Ulcers	☐ Thyroid Disease	☐ Glaucoma
☐ High Blood Pressure	☐ Diabetes	☐ Emphysema	☐ Chemo. (Cancer, Leukemia)	☐ Pain in Jaw Joints
☐ Blood Disease	☐ Scarlet Fever	☐ Tuberculosis	☐ Arthritis	☐ HIV +
☐ Rheumatic Fever	☐ Anemia	☐ Asthma	☐ Rheumatism	☐ Hepatitis
☐ Heart Murmur	☐ Kidney Trouble	☐ Hay Fever	☐ Cortisone Medicine	☐ Hemophilia
☐ Venereal Disease	☐ Epilepsy or Seizures	☐ Nervousness	☐ Sickle Cell Disease	☐ Bruise Easily

Mark any of the following medications you are allergic to:

☐ Local Anesthetics ☐ Penicillin or other antibiotic ☐ Sulfa Drugs
☐ Aspirin ☐ Codeine or other narcotics ☐ Barbiturates, sedatives, or sleeping pills
☐ Lodine ☐ Other ____

Medical History Updated:

______________________ ______________________ ______________________
Dr. Date Dr. Date Dr. Date

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if any medicines change I will inform my dentist at the next appointment.

Signature of Patient / Parent / Guardian______________________________

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FINANCIAL POLICY

PATIENT NAME: ________________________________

Dear Patient:

Thank you for choosing Knox Village Dentistry & Orthodontics as your dental care provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatments needed to maintain your dental health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our Office Manager.

We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Form prior to seeing the dentist.

Payment for services is due at the time services are rendered. We accept cash, checks, and credit cards. We will be happy to process your insurance claim for you as long as you provide us with adequate information. However, you must understand the following:

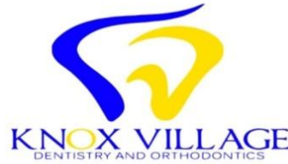
1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company.
2. All charges are your responsibility, regardless of whether your insurance company pays. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select services they will not cover.
3. Fees for the services, along with unpaid deductibles and co-payments are due at the time of treatment. We accept cash, checks, or credit cards.
4. If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to help expedite the processing of your claim.
5. If the insurance company does not pay in full within 45 days, we require you to pay the balance due with cash, check, or credit card.
6. You will be responsible for notifying us of any changes in address, job status, insurance status, and availability of benefits immediately. A failure to do so may result in a different balance for which you will be responsible.
7. A 5% courtesy on statements of $500 or more that are paid in full by cash or check prior to or at the time of the first treatment appointment.
8. For patients who wish to pay for treatment over an extended period of time, we offer a payment plan that is administered by an independent company. The Treatment Coordinator will provide you with all the details.

Please do note that unless canceled at least 24 hours in advance, you may be charged for missed appointments at the rate of $25.00. Please call if you have to reschedule.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Again, thank you for choosing us as your dental provider. We appreciate your trust in us and the opportunity to serve you.

Signature of Patient/Parent/Guardian (if patient is under 18, parent or guardian must sign) Date



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Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 acknowledge that I have received 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 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 health care 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: ______________________________

Signature: ______________________________

Date: ______________________________

Office Use Only

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

Date	Initials	Reasons