Confidential Dental and Medical History

Patient Information

Patient's Name ________________________________ Age________ Date of Birth ____________________

Address ________________________________ City, State, Zip ____________________

Home Phone ________________ Work ____________________ Cell ____________________

SS# ________________________________ Marital Status: **SINGLE MARRIED WIDOWED DIVORCED**

Drivers License # ________________________________ State Issued ____________________

E-mail ________________________________ Best Contact- **EMAIL CELL TEXT HOME** Best Time to Reach You- ____________

Employer ________________ Employer Address ________________________________

Spouse's Name ________________________ Spouse's Phone: (Work) ____________(Cell) ____________

Emergency Contact ________________ Relation ____________ Emergency Phone ____________

Do you have dental insurance? **YES** **NO** If yes, please complete the Insurance Information form

HOW DID YOU HEAR ABOUT US ? ____

Preferred Pharmacy: ________________________ **Pharmacy Phone #:** ____________________

Parent of MINOR Child Information

Mother Name ____________________ **Date of Birth** ________________ **SS#:** ________________

Address ________________________________ City, State, Zip ____________________

Home Phone ________________ Work ____________________ Cell ____________________

Employer ________________ Employer Address ________________________________

Driver License #: ________________________________ State Issued: ____________________

Father Name ____________________ **Date of Birth** ________________ **SS#:** ________________

Address ________________________________ City, State, Zip ____________________

Home Phone ________________ Work ____________________ Cell ____________________

Employer ________________ Employer Address ________________________________

Driver License #: ________________________________ State Issued: ____________________

Who is responsible for payment? ____

Derrick Carter D.M.D.
571 S. 6th St.
Macclenny, FL 32063
904.653.3333

Patient Name: ____________________ **Preferred Pharmacy:** ____________________

In order for us to provide you with the safest and best possible care, please complete this Medical & Dental History form. All information is kept strictly confidential.

Sex: **Male** **Female**

HEIGHT ____________ **WEIGHT** ____________

Women: Are you pregnant? **Yes / No**
If yes, what is your estimated due date? ____________________
Are you nursing? **Yes / No**

Do you have or have you ever had:

	YES	NO		YES	NO		YES	NO
Artificial Joints / Joint Replacement	____	____	Heart Attack	____	____	High Blood Pressure	____	____
Congenital Heart Condition	____	____	Diabetes	____	____	Radiation Therapy	____	____
Artificial Heart Valve	____	____	HIV	____	____	Abnormal Bleeding	____	____
Heart Murmur	____	____	Stroke	____	____	Bruise Easily	____	____
Endocarditis	____	____	Hepatitis	____	____	Sinus Problems	____	____
*Heart Transplant	____	____	Cancer	____	____	Tuberculosis	____	____

Are you taking or *have you ever taken* Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Fosamax, Actonel, Boniva, Aredia, Zometa, Xgeva)............................ **Yes / No**

Have you ever been advised to take antibiotics prior to dental treatment for conditions not related to your teeth?

Yes / No For what condition? ____

Any surgeries and/or hospitalizations? **YES NO Explain:** ____

____

Have you ever had any excessive bleeding requiring special treatment? **YES NO** ____________________

Use of alcohol: **YES NO | DAILY WEEKLY MONTHLY** Use of recreational drugs: **YES NO**

Do you use tobacco? **YES NO** What type and how much per day? ____________________

Please list ALL medications you are on:____

____

____

Are you allergic to any of the following?

	YES	NO		YES	NO	Other	Yes	NO
Dental Anesthetics	____	____	Tetracycline	____	____	Please list:____________		
Latex	____	____	Sulfa Drugs	____	____	____________		
Codeine	____	____	Aspirin	____	____	____________		
Erythromycin	____	____	Metals	____	____	____________		
Penicillin	____	____	Jewelry	____	____	____________		

Are there any other conditions we should know about? ____

____

PLEASE READ THE FOLLOWING CAREFULLY: To the best of my knowledge all of the preceding answers are true and correct. If I ever have a change in my health, I will inform the office at the next appointment. I do hereby authorize and request for myself or the above named patient, dental services and/or whatever procedures the doctor may deem necessary. I also authorize the administration of those local anesthetic or pre-medications which may be deemed advisable.

____

Signature of Patient or Guardian **Print** **Date**

Derrick Carter D.M.D.
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Financial Agreement

By signing this document, I agree that my signature on file shall represent consent for all charge card transactions. I also understand that Dr. Carter's office both reports to and uses credit bureau files for purposes of finance and collection of accounts and any and all charges incurred in order to collect on a past due balance are also my responsibility. Parental consent for treatment determines account responsibility. My signature below also acts as signature on file for insurance claims and I give permission to Derrick Carter, DMD to file and disclose my health information to my insurance company.

I have read and understand the terms of the financial agreement with Derrick Carter, DMD. My signature below represents agreement and consent to these terms.

____

Print Name

____

Signature of Patient or Guardian   Date

****

Acknowledgment Of Receipt Of Notice Of Privacy Practices

(You May Refuse to Sign This Acknowledgment)

I have received a copy of the NOTICE OF PRIVACY PRACTICES. I hereby authorize you to share/disclose my health information with the following persons/parties:

____

____

____

____

PRINT NAME

____

SIGNATURE OF PATIENT or if minor, SIGNATURE OF LEGAL GUARDIAN

OFFICE USE ONLY:

As privacy officer, I attempted to obtain the patient's (or representative's) signature on this ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES document, but did not because:

____ It was emergency treatment

____ I could not communicate with the patient

____ The patient refused to sign

____ The patient was unable to sign because

____

____ Other (please describe) ______________

____

If you are the legal representative of the patient, please print the patient's name(s) and describe your authority/relationship.

____

____

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Insurance Information Form

Primary Insurance

Subscriber's Name ________________________ Relation to Patient ________________________

Subscriber's SS#________________________Subscriber's Date of Birth ________________

Subscriber Address: ____

City, State, Zip: ________________________Subscriber Phone: ________________________

Employer/Co. Name ________________________Employer Phone: ________________________

Employer/Co. Address, City, State, Zip____

____

Insurance Carrier's Name________________________________ Phone ________________

Subscriber ID: ________________________________Group #________________________

Insurance Carrier Address,City,State,Zip____

____

OFFICE POLICY REGARDING INSURANCE:

Your dental insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. The responsibility of payment ultimately lies with the patient, not the insurance company. As a courtesy, we will file your claim on your behalf.

I understand that I am required to pay my "Estimated Patient Portion" and any deductible due, to Derrick Carter, D.M.D. at the time of my visit. Failure to provide our office with all the information necessary to file your insurance claim, including your social security number, will require full payment at the time of service. Any portion of treatment that the insurance does not cover is the patient's responsibility. A statement will be sent to the patient for any balance which is not paid by the insurance company after 45 days. I hereby authorize the release of any dental information that is needed to file my insurance.

I consent to treatment for myself/family under 18 years old. I have read the above statements and understand that I am responsible for payment in full after (45) days of my treatment, regardless of any delay in payment(s) by my insurance company. I understand that a 1.5% per month late charge may be added to my account for any overdue balance that is my responsibility. My signature below represents both consent for assignment of benefits to Derrick Carter, DMD and release of dental records to my insurance company as needed for claim processing.

____

Signature of Patient or Guardian Print Name Date

Derrick Carter D.M.D.
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Appointment Cancellation Policy Agreement

Please check the box that best describes your appointment habits:

☐ I always keep my scheduled appointments.

☐ I always give plenty of notice if I need to cancel/change a scheduled appointment.

☐ I find it difficult to make my scheduled appointments and I will need several reminders.

Macclenny Family Dental is committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen. **Please call us at (904) 653-3333 within 48 hours prior to your scheduled appointment to notify us of any changes or cancellations.** If less than 48 hour notification is not given, there will be a minimum charge of $35.00 for a late cancellation and $50.00 for a no show (no notification) appointment. ________ Initial

If you are not able to reach a staff member when calling, please leave a voice message or reply to your text message, as both of these constitute as canceling.

Unconfirmed appointments are double-booked and will result in extended wait times.

Two no-show appointments or last minute cancellations within a 1 year period can result in dismissal from the practice. _______ Initial

Please sign below to consent to these terms.

____

Patient Signature (Patient's Parent/Guardian if under 18)

____

Date

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