DUNN DENTAL
THOMAS L. DUNN, DMD, LLC

*Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form* ***completely in ink.*** *If you have any questions or need assistance, please ask us – we will be happy to help.*

Patient #_____
SS#/SIN_____
Date _____

## Patient Information (CONFIDENTIAL):

Name:_____ Birthdate:_____ Phone_____

Address:_____ City: _____ State: _____ Zip: _____

Email: _____ Cell Phone: _____

Circle your status: Minor Single Married Divorced Widowed Separated

Name of School/College (For Students): _____ City: _____ State: _____ Zip: _____

Patient's or Parent/Guardian's Employer: _____ Work Phone: _____

Employer's Address: _____ City: _____ State: ____ Zip: _____

Spouse or Parent/Guardian's Name: _____ Spouse Employer: _____

Spouse Work Phone: _____ Who Referred You? _____

Person to contact in case of emergency: _____ Phone: _____

## Responsible Party

Person Responsible for this Account: _____ Relationship to Patient: _____

Address: _____ Home Phone: _____

Email: _____ Cell Phone: _____

Driver's License #: _____ Birthdate: _____ Financial Institution: _____

Employer: _____ Work Phone: _____ SS#: _____

Is this person a patient in our office? Yes____ No____

*For your convenience we offer the following methods of payment.* ***Please cirlce the option you prefer.*** *Payment is due in full at each appointment.*

Cash Personal Check Visa Credit Card Mastercard Credit Card I wish to discuss the office's payment policy

## Insurance Information

Name of Insured: _____ Relationship to Patient: _____
Birthdate: _____ SS#: _____ Date Employed: _____

Name of Employer: _____ Union or Local # _____ Date Employed: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group# _____ Policy/ID # _____
Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

How much is your deductible? _____ How much have you used? _____ Max Annual Benefit: _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes_____ No _____

IF YES, COMPLETE THE FOLLOWING:

Name of Insured: _____ Relationship to Patient: _____
Birthdate: _____ SS#: _____ Date Employed: _____

Name of Employer: _____ Union or Local # _____ Date Employed: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group# _____ Policy/ID # _____
Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

How much is your deductible? _____ How much have you used? _____ Max Annual Benefit: _____

## Patient Medical History

Physician: _____ Office: _____ Date Last Exam: _____

| | Yes | No |
|---|---|---|
| 1. Are you under medical treatment now? | ☐ | ☐ |
| 2. Have you been hospitalized for any surgical procedure or serious illness within the last 5 years? If yes, please explain:_____ | ☐ | ☐ |
| 3. Are you taking any medication(s) including non-precription medicine? If yes, what medicine(s) are you taking?_____ | ☐ | ☐ |
| 4. Have you ever taken Fen-Phen/Redux? | ☐ | ☐ |
| 5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? | ☐ | ☐ |
| 6. Have you ever taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? | ☐ | ☐ |
| 7. Do you use tobacco? | ☐ | ☐ |
| 8. Do you use controlled substances? | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| 10. Are you wearing contact lenses? | ☐ | ☐ |
| 11. Are you allergic to or have had any reactions to the following: | | |
| Local Anesthetics (e.g. Novacain) | ☐ | ☐ |
| Penicillin or any other Antibiotics | ☐ | ☐ |
| Sulfa Drugs | ☐ | ☐ |
| Barbiturates | ☐ | ☐ |
| Sedatives | ☐ | ☐ |
| Iodine | ☐ | ☐ |
| Aspirin | ☐ | ☐ |
| Any Metals (e.g. nickel, mercury, etc.) | ☐ | ☐ |
| Latex Rubber | ☐ | ☐ |
| Other _____ | | |
| 12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? | ☐ | ☐ |
| 13. Women Only: | | |
| Are you pregnant or think you may be pregnant? | ☐ | ☐ |
| Are you nursing? | ☐ | ☐ |
| Are you taking oral contraceptives? | ☐ | ☐ |

9. **Do you have any of the following:**

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | ☐ | ☐ | Heart Disease | ☐ | ☐ | Chest Pains | ☐ | ☐ |
| Heart Attack | ☐ | ☐ | Cardiac Pacemaker | ☐ | ☐ | Easily Winded | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Stroke | ☐ | ☐ |
| Swollen Ankles | ☐ | ☐ | Angina | ☐ | ☐ | Hay Fever / Allergies | ☐ | ☐ |
| Fainting / Seizures | ☐ | ☐ | Frequently Tired | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Asthma | ☐ | ☐ | Anemia | ☐ | ☐ | Radiation Therapy | ☐ | ☐ |
| Low Blood Pressure | ☐ | ☐ | Emphysema | ☐ | ☐ | Glaucoma | ☐ | ☐ |
| Epilepsy / Convulsions | ☐ | ☐ | Cancer | ☐ | ☐ | Recent Weight Loss | ☐ | ☐ |
| Leukemia | ☐ | ☐ | Arthritis | ☐ | ☐ | Liver Disease | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Joint Replacement / Implant | ☐ | ☐ | Heart Trouble | ☐ | ☐ |
| Kidney Diseases | ☐ | ☐ | Hepatitis / Jaundice | ☐ | ☐ | Respiratory Problems | ☐ | ☐ |
| AIDS or HIV Infection | ☐ | ☐ | Sexually Transmitted Disease | ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ |
| Thyroid Problem | ☐ | ☐ | Stomach Troubles / Ulcers | ☐ | ☐ | Other _____ | ☐ | ☐ |

## Patient Dental History

Physician: _____ Office: _____ Date Last Exam: _____

| | Yes | No |
|---|---|---|
| 1. Do your gums bleed while brushing or flossing? | ☐ | ☐ |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | ☐ | ☐ |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | ☐ | ☐ |
| 4. Do you feel pain to any or your teeth? | ☐ | ☐ |
| 5. Do you have any sores or lumps in or near your mouth? | ☐ | ☐ |
| 6. Have you had any head, neck, or jaw injuries? | ☐ | ☐ |
| 7. Have you ever experienced any of the following problems in your jaw? | | |
| Clicking | ☐ | ☐ |
| Pain (joint, ear, side of face) | ☐ | ☐ |
| Difficulty in opening or closing | ☐ | ☐ |
| Difficulty in chewing | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| 8. Do you have frequent headaches? | ☐ | ☐ |
| 9. Do you clench or grind your teeth? | ☐ | ☐ |
| 10. Do you bite your lips or cheeks frequently? | ☐ | ☐ |
| 11. Have you ever had any difficult extractions in the past? | ☐ | ☐ |
| 12. Have you ever had any prolonged bleeding following extractions? | ☐ | ☐ |
| 13. Have you had any orthodontic treatment? | ☐ | ☐ |
| 14. Do you wear dentures or partials? If yes, date of placement_____ | ☐ | ☐ |
| 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | ☐ | ☐ |
| 16. Do you like your smile? | ☐ | ☐ |

## Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. 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 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.

Signature of patient (or parent/guardian if minor)_____Date_____

Doctor's Comments _____

_____

_____

Signature _____ Date _____

## Financial Policy

Thank you for choosing Dr. Thomas Dunn Family Dentistry.

We are committed to your successful treatment. Please sign this to acknowledge your understanding of our Financial Policy. Payment is due at the time of service. We accept cash, checks, Visa, Mastercard and Care Credit.
If you have insurance, the payment of your deductible and estimated patient portion is due at the time of service. You have a contract with your dental insurance company. We are not a party to that contract, and while we do our best to obtain information from your insurance company, it is ultimately your responsibility to understand your policy and its limitations. When we accept your insurance, you are still responsible for charges in full for all treatment. We provide an estimate that you should consider a guideline until final insurance payment is received and your account has been reconciled. We make every effort to provide accurate estimates, but our office can make no guarantee that insurance
payments will match our estimate. Claims are submitted promptly to your insurance company after treatment. Any claim that is not paid after 61 days is billed directly to you. At your request, we will gladly process your predeterminations, but please be aware that predeterminations are not guarantees of payment.
We charge what is usual and customary for our area. You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary rates. Accounts due over 30 days are assessed a monthly finance charge of 1 .5%, or an annual percentage rate of 18%. You (or the party responsible for your account) agree to provide total payment for procedures performed in this office, including any treatment not deemed to be a benefit of your dental or other insurance.

☐ I have read the above conditions of treatment and agree to their content.

**Signature of guarantor of payment/responsible party:**
Signature: _____ Date: _____

Relationship to patient: _____

## HIPPA Acknowledgment

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

☐ **I understand that I may inspect or copy the protected health information described by this authorization.**

**Acknowledgment Date** _____