

JERRY BOYD, DDS, PC

WELCOME TO OUR PRACTICE

Patient Information

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____ Address 2: _____

City: _____ State _____ Zip: _____

Home Phone: _____ Cell: _____ Work Phone: _____ Ext: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers License: _____

E-mail: _____

Employment Status: Full Time Part Time Retired

Employer: _____ Address: _____

Student Status: Full Time Part Time

School Name: _____ City & State: _____

Preferred Pharmacy: _____ Phone: _____

Patient is: Policy Holder Responsible Party

How did you hear about our practice? _____

Spouse and/or Parent Information

First Name: _____

Address: _____

City: _____ State _____ Zip: _____

Home Phone: _____ Cell: _____ Work Phone: _____ Ext: _____

Birth Date: _____ Soc. Sec: _____ Drivers License: _____

Responsible Party (if someone other than patient)

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____

City: _____ State _____ Zip: _____

Home Phone: _____ Cell: _____ Work Phone: _____ Ext: _____

Birth Date: _____ Soc. Sec: _____ Drivers License: _____

Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Primary Insurance Information

Name of Insured: _____ Relationship to Patient: Self Spouse Child Other

Insured Soc Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Phone: _____ Phone: _____

DENTAL HISTORY

Why have you come to the dentist today? _____

Are you currently in pain Yes No

How long since your last dental cleaning? _____

Have you ever had a serious/difficult problem associated with any previous dental work? Yes No

Do you or have you ever experienced discomfort/pain in your jaw joint (TMJ/TMD)? Yes No

Your current dental health is Good Fair Poor

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

Are your gums swollen and/or tender? Yes No

How many times a WEEK do you floss? _____

How many times a DAY do you brush? _____

Types of bristles? Hard Medium Soft

Do you have pain with brushing? Yes No

Do you have pain in your jaw joints? Yes No

Do you have bad breath even with regular brushing and/or mouthwash? Yes No

Do you have dry mouth? Yes No

Are you a mouth breather? Yes No

Are you aware of any sores or growths in your mouth? Yes No

Do you grind your teeth? Yes No

Do you bite your fingernails? Yes No

Do you regularly collect food between any of your teeth? Yes No

Do you have any loose teeth? Yes No

Do you have any broken fillings? Yes No

Are any teeth sensitive to heat, cold or sweets? Yes No

Are any teeth tender to bite on? Yes No

Have you had orthodontic treatment? Yes No

Have you had periodontal treatment? Yes No

Are you concerned about the health effects of metal fillings? Yes No

Are you concerned about the appearance of metal fillings? Yes No

Are you interested in preventive treatment against decay? Yes No

Are you interested in improving the appearance of your smile? Yes No

Are you interested in whitening your teeth? Yes No

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

DATE

MEDICAL HISTORY

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 could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No _____
- Have you recently been hospitalized or had a major operation? Yes No List: _____
- Have you ever had a serious head or neck injury? Yes No List: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Do you use tobacco? Yes No _____
- Are you taking any prescription or over the counter drugs? Yes No List: _____
- _____
- _____
- _____

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 Local Anesthetics Other _____

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

<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Shingles
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Congenital Heart Disorder*	<input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Angina	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Heart Murmur*	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Pace Maker*	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Stomach/Intestinal Disease
<input type="checkbox"/> Artificial Heart Valve*	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Mitral Valve Prolapse*	<input type="checkbox"/> Stroke
<input type="checkbox"/> Artificial Joint*	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Radiation Treatments	<input type="checkbox"/> Tumors or Growth
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Herpes/Fever Blisters	<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Breathing Problem	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Renal Dialysis	<input type="checkbox"/> Yellow Jaundice
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Fainting Spells/Dizziness	<input type="checkbox"/> Hives or Rash	<input type="checkbox"/> Rheumatic Fever*	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Rheumatism	

*Condition may require medication

Have you ever had any serious illness not listed above Yes No _____

Are you being treated for osteoporosis? Yes No

Have you taken any of the drugs listed below? For how long? For what treatment? _____

- Oral: Actonel (risedronate) Yes No
- Boniva (ibandronate) Yes No
- Fosamax (alendronate) Yes No
- Fosamax Plus D (alendronate) Yes No
- Skelid (tiludronate) Yes No
- Didronel (etidronate) Yes No

- IV: Aredia (pamidronate) Yes No
- Zometa (zolendronate) Yes No
- Bonefos (clodronate) Yes No

ABOUT FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

If you have dental or medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment is due at the time services are rendered. We accept cash, check and most major credit cards. We will be happy to process your insurance claim for you as we accept assignment of insurance benefits, however, we ask that payment for any out-of-pocket expenses be paid at the time of treatment. **IN ALL CIRCUMSTANCES THE PATIENT IS RESPONSIBLE FOR ALL COSTS NOT PAID BY THE INSURANCE COMPANY.**

Returned checks and balances older than 30 days will be subject to additional collection fees (and interest charges of 1 1/2% per month). Charges may also be made for broken appointments and appointments cancelled without 24 hours advance notice.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. It is your responsibility to be sure your insurance is in effect and up to date.
2. Our fees are generally considered to fall within the acceptable range by most companies and therefore are covered up to a maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "U.C.R.". "U.C.R." is defined as usual, customary and reasonable fees for this region. Thus, our fees are considered usual, customary and reasonable by most companies. Please understand the amount we figure is only an estimate. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While filing insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.