# 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 ? _____

Primary Care Physician: _____

Primary care Physician phone: _____

Preferred Pharmacy (Name & Location): _____

Pharmacy Phone: _____

Our office utilizes an automated system for appointment reminders and to confirm appointments. Unconfirmed appointments are double booked. We DO NOT send promotional messages or sell your information to third parties.

Would you like to receive these reminders? **YES** **NO**

Do you ever have clicking, popping, or pain in your jaw? **YES** **NO** Is it accompanied by pain? **YES** **NO**

Are you experiencing dental pain today? **YES** **NO**

Do you have dry mouth? **YES** **NO**

Do you have any specific dental concerns today? **YES** **NO**

If yes, please explain: _____

_____

DENTISTRY FOR ALL AGES
Implants - Crowns - Dentures - Surgery

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

**Patient Name:** _____ **Date of Birth:** _____

**Preferred Pharmacy:** _____ **Pharmacy Phone:** _____

**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 <u>strictly confidential</u>.**

**Sex: Male Female**

**HEIGHT** _____ **WEIGHT** _____

**<u>Women</u>:** 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/AIDS | ____ | ____ | Abnormal Bleeding | ____ | ____ |
| Heart Murmur | ____ | ____ | Stroke | ____ | ____ | Bruise Easily | ____ | ____ |
| Endocarditis | ____ | ____ | Hepatitis | ____ | ____ | Sinus Problems | ____ | ____ |
| *Heart Transplant | ____ | ____ | Cancer | ____ | ____ | Tuberculosis | ____ | ____ |
| Osteoporosis | ____ | ____ | | | | | | |

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** Medical Marijuana: **YES NO**

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

Do you vape? **YES NO**

**Please list <u>ALL</u> prescription medications you are on (including counter medications or supplements you are on: (This includes but is not limited to Vitamins, Fish Oil, Melatonin, St. Johns Wart, etc)**:_____

_____

_____

_____

**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**


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# Financial Agreement
## (See attached document)

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment is expected, in full, at the first appointment. By signing this document, I agree to pay for all services rendered at the time of service. I also agree that my signature on file shall represent consent for all charge card transactions. I 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 represents my understanding and acceptance of the given terms. My signature below acts as 'signature on file' for insurance claims and also gives permission to Derrick Carter, DMD to file and disclose my health information to my insurance company and/or a collection agency/attorney in order to collect on claims and any unpaid debt I may owe.

I acknowledge receipt of the attached financial agreement with Derrick Carter, DMD and have read and understand the terms. 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. My signature below also gives permission to Derrick Carter, DMD to file and disclose my personal dental information to both my insurance company or a collection agency/attorney to collect on any claims or unpaid debt I may owe.

_____

Signature of Patient or Guardian Print Name Date

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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 per hour booked 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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# Parent of MINOR Child Information

**Name of minor child:** _____ **Date of Birth:** _____

**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: _____

**The accompanying parent is responsible for all payments, delinquencies, and fees. We do not facilitate 3rd party payments.**

**If another family member may bring your child to appointments, please lists the name, relationship, and phone numbers of the family members below. **Note: If family members are not authorized to discuss or consent to treatment, a parent is required to accompany the child, until age 18.**

I do **NOT** authorize Derrick Carter, DMD and staff to discuss my child's treatment or obtain consent for any treatment from family members. Only parents are able to consent. I understand that I must accompany my child (until age 18) to all appointments.

**Signature:** _____ **Date:** _____

**Print:** _____

I **DO** authorize the below family members to discuss my child's treatment needs, book appointments, and make treatment decisions in my absence. I understand I am responsible for any balance due as a result of decisions made by the authorized family members.

**Signature** _____ **Date:** _____

**Print** _____

**Name/Relation/Phone:** _____

**Name/Relation/Phone:** _____

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