Felix Care Dental

PATIENT

Name:_____ Name you prefer to be called_____ Date_____ / _____ / _____

Address _____ Evening Phone (_____)_____-_____

City_____ State_____ Zip_____ Daytime Phone (_____)_____-_____

SS #_____-_____-_____ Birthdate _____/_____/_____ Sex ____ Text Phone (_____)_____-_____

Occupation or School (if student)_____ E-mail _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed Whom may we thank for referring you? _____

In case of emergency contact:_____ Phone:_____ Relationship _____

MINORS ONLY

Person responsible for account_____ Phone (_____)_____ - _____

Address_____ City_____ State_____ Zip_____

Signature _____ Relationship to patient ☐ Parent ☐ Guardian ☐ Other_____

PRIMARY INSURANCE

Subscriber Name _____

Relationship to patient _____

Birthdate _____

SS# _____

Employer _____

Insurance Company _____

Group # _____

ADDITIONAL INSURANCE

Subscriber Name _____

Relationship to patient _____

Birthdate _____

SS# _____

Employer _____

Ins. Company _____

Group #_____

APPOINTMENTS

We recognize the value of your time. Except in emergency cases, you may expect us to be on time, and we appreciate the same courtesy. If you are 15 minutes late for an appointment you are subject to rescheduling.

Patients under 18 years old, at all appointments, must be accompanied by an adult who will be responsible for payment and authorization of any required work.

INSURANCE

We are happy to process your insurance forms for you. We ask that you be knowledgeable about the benefits and effective date of your insurance coverage and the coverage for your dependents. Policies will vary.

Your dental insurance is an agreement between you and your insurance company. We are pleased to process your insurance claims with the understanding that you, the patient, are responsible for any expenses not covered by your present carrier. An estimate of your dental charges will be given at your request; however the estimate is NOT a guarantee of your expenses or payment by your insurance company.

OUR FINANCIAL POLICY

In order that you may have a definite understanding regarding the payment policies of our office, they are listed below:

1. Co-payments and outstanding balances are to be paid prior to treatment.
2. Fees listed on estimates are subject to change, unless prepayment has been made.
3. Discounts are not applicable with insurance coverage.
4. There is a $25 fee for returned checks

Initial here

OUR GUARANTEE

We are proud to guarantee our work. We give a five year guarantee on crowns and a two year guarantee on fillings received in our office. We extend this guarantee to our patients that complete all recommended treatment and keep all recommended hygiene and restorative appointments.

Thank you for taking the time to read our office policies. If you have any questions, please ask any team member.

MEDICAL HISTORY

Physician Name _____ Phone_____ Last Physician Visit ____/_____/_____

Please mark (Y)es or (N)o to each of the following conditions:

Osteoporosis	☐Y☐ N	Epilepsy	☐Y☐ N	Sinus Problems	☐Y☐ N
Implants/Pins/Screws	☐Y☐ N	Seizures	☐Y☐ N	Emphysema	☐Y☐ N
Heart Defect	☐Y☐ N	Diabetes	☐Y☐ N	Allergies	☐Y☐ N
Heart Murmur	☐Y☐ N	Back Problems	☐Y☐ N	Asthma	☐Y☐ N
Rheumatic Fever	☐Y☐ N	High Blood Pressure	☐Y☐ N	Thyroid problems	☐Y☐ N
Taken Fen-Phen	☐Y☐ N	Pacemaker	☐Y☐ N	Frequent headaches	☐Y☐ N
Endocarditis	☐Y☐ N	Fainting Spells	☐Y☐ N	Arthritis	☐Y☐ N
		Fever Blisters	☐Y☐ N	Psychiatric treatment	☐Y☐ N
Cancer	☐Y☐ N	Iodine Allergy	☐Y☐ N		
HIV+/ AIDS	☐Y☐ N	Stomach Problems	☐Y☐ N	Abnormal Bleeding	☐Y☐ N
Radio/Chemo Therapy	☐Y☐ N	Colitis	☐Y☐ N	Anemia	☐Y☐ N
Tuberculosis	☐Y☐ N	Kidney Problems	☐Y☐ N	Blood Disease	☐Y☐ N
Heart Attack	☐Y☐ N	Chemical dependency	☐Y☐ N	Hepatitis Type____	☐Y☐ N
Stroke	☐Y☐ N	Liver Problems	☐Y☐ N	Surgery/Hospitalization	☐Y☐ N

For Office Use Only
HT:_____
BP: _____/_____
PULSE: _____
PREMED: Y N
Notes

Are you allergic to any of the following? Please mark (Y)es or (N)o for each:

Penicillin	☐Y☐ N	Dental Anesthetics	☐Y☐ N	Codeine	☐Y☐ N	Other
Tetracycline	☐Y☐ N	Latex	☐Y☐ N	Jewelry	☐Y☐ N	
Erythromycin	☐Y☐ N	Aspirin	☐Y☐ N	Metals	☐Y☐ N	

Are you taking any medications? If so please list:

Medication	Dose	When Taken	Condition	Medication	Dose	When Taken	Condition

Do you smoke? ☐Y☐ N #_____ Cig or Pack per day Are you generally healthy? ☐Yes☐ No

Do you have any other disease or condition we should be aware of? ☐Y☐ N If yes please explain:

Women Only
Are you taking birth control pills? ☐Y☐ N **Are you pregnant?** ☐Y☐ N If Yes, what week?___ Are you nursing? ☐Y☐ N

DENTAL

Reason for today's Visit:: _____ Date of last dental visit: _____ / _____ / _____

Former Dentist: _____ Date of Last X-rays: _____ / _____ / _____

Please check if you have any of the following problems:

☐ **PAIN NOW**	☐ Grinding Teeth	☐ Bleeding Gums	☐ Trapping Food	☐ Mouth Sores
☐ Sensitivity to Sweets	☐ Gum Disease	☐ Pain when Biting	☐ Broken Fillings	☐ Sensitivity to Cold
☐ Clicking/Locking Jaw	☐ Loose Teeth	☐ Bad Breath	Other:_____	

Please mark all you are interested in:

☐ Home Bleaching	☐ Night Guard	☐ Veneers	☐ Amalgam (silver) Filling Removal
☐In-Office Bleaching	☐ Sports Guard	☐ Bonding	☐ Other:_____

Authorization and Release

The information on this form is accurate and complete to the best of my knowledge. It is my responsibility to inform the dental office of any changes in my medical status or other information. I will not hold my dentist or any member of his staff responsible for errors or omissions that I have made in the completion of this form. I authorize the administration, with the patient's consent, of medications, and the performance of necessary diagnostic and therapeutic procedures as deemed appropriate by the dentist. I authorize the Doctor choose and employ such assistance as he deems fit. I authorize the dental staff to release information during dental care to third party payers and other health practitioners. I give my permission to the dentist to contact my physician or previous dentist if needed. I understand the use of anesthetic agents embodies a certain risk. I agree to be responsible for payment of all services rendered on my behalf or that of my dependants.

Signature: Date: Relationship to Patient:

D.D.S. Signature_____