Welcome

We at Summerfield family dentistry would like to thank you for choosing our office for your dental care. We appreciate your confidence & look forward to providing you with exceptional dental care.

Patient Information (CONFIDENTIAL)

Date____________________

Name_________________________________Birthdate____________SS#______________________
Preferred Name: ________________________
Address______________________________City____________________State_______Zip_________
Home Phone_________________Work Phone_________________Cell Phone___________________
Email_________________________________Employer______________________________________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ College Student
If Student, Name of College____________________City__________State______ ☐ Full Time ☐Part Time
Are any immediate family members already a patient in our office? ______________________________
Whom May We Thank for Referring You?____

Spouse or Parent/Guardian's Name________________________________
Employer______________________________Work Phone___________Cell Phone____________
Person to Contact in Case of Emergency____________________________Phone______________

Responsible Party

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Name of Person Responsible for this Account____
Relationship___________________________Birthdate_______________SS#__________________
Address____Home Phone_________________
Cell Phone___________May we call you here? ☐ Yes ☐ No Email______________________________
Employer___________________________________Work Phone_________________________

Insurance Information

Name of Insured_____________________________Relationship to Patient___________________
Birthdate__________________SS#______________Name of Employer_________________________
Work Phone______________________
Insurance Company_____________________Group #_______________Policy/ID #______________
Address________________________City______________State_______Zip_________
Phone Number___________________

Do You Have Any Secondary Insurance? ☐ Yes ☐ No If Yes, Complete the following:

Secondary Insurance Information

Name of Insured_____________________________Relationship to Patient___________________
Birthdate__________________SS#______________Name of Employer_________________________
Work Phone______________________
Insurance Company_____________________Group #_______________Policy/ID #______________
Ins. Co. Address__________________________City______________State_______Zip___________
Phone Number______________________________

Dental History

Reason for today's visit________________ Date of last dental cleaning________________

Date and purpose of last dental visit________________

Former Dentist________________

What are you looking for in a dental care provider?________________

How often do you brush?________________ How often do you floss?________________

Have you recently or are you now experiencing any dental pain?________________

Have you ever been told you suffer from TMJ?________________

What is the one thing you would change about your smile if you could?________________

____

Clicking/popping jaw	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Dental Phobia	☐ Yes	☐ No
Are you pleased with your smile?	☐ Yes	☐ No
Have you bleached your teeth in the past?	☐ Yes	☐ No
Do you catch food between the teeth?	☐ Yes	☐ No
Sensitive to cold/hot/sweets?	☐ Yes	☐ No
Orthodontic Treatment	☐ Yes	☐ No

Medical History

Name of Your Physician:________________ Office Telephone:________________

Address of Your Physician:________________

1. Have you ever been hospitalized, had any major operation or had any serious illnesses?.........Y N
   If yes, explain:________________
   ____

2. Have you been under a physician's care in the last 2 years?..Y N
   If yes, explain:________________
   ____

3. With regard to cigarette smoking, how would you classify yourself: Current smoker Ex-smoker Never smoker

4. Do you currently use smokeless tobacco(e.g., snuff, plug)?...Y N
   If yes, about how many times do you use smokeless tobacco per day?______

5. Do you currently drink alcoholic beverages?...Y N
   If yes, about how many drinks do you have per week?_______

6. Do you have (or have ever been told you had) any of the following conditions? (circle all that apply)
   a. Congenital heart problems
   b. Infective endocarditis or other heart infection
   c. Artificial heart valves
   d. Heart Transplant
   e. Artificial joints or prostheses

7. Have you ever had an allergic reaction, or any other unusual reaction, to any of the following medications or substances? If yes, what reaction(s) did you have?
   a. Penicillin Y N (explain)________________
   b. Sulfa or other antibiotics Y N (explain)________________
   c. Aspirin Y N (explain)________________
   d. Codeine or morphine Y N (explain)________________
   e. Dental anesthetic Y N (explain)________________
   f. Latex Y N (explain)________________
   g. Airborne substances (e.g pollen, perfume) Y N (explain)________________
   h. Other medications or substances (explain)________________

8. Do you have, or ever been told you had, any of the following conditions?

a. High blood pressure (hypertension)........ Y N
b. High cholesterol........ Y N
c. Heart disease (e.g. angina, coronary artery disease, congestive heart failure)........ Y N
d. Diabetes (sugar diabetes, blood sugar problems)........ Y N
e. Cancer or tumors........ Y N
f. Inflammatory diseases (e.g. arthritis, rheumatism, lupus, fibromyalgia)........ Y N
g. Frequent headaches........ Y N
h. Asthma, emphysema, or other lung disease........ Y N
i. Thyroid problems........ Y N
j. Epilepsy or seizure disorders........ Y N
k. Fainting or dizzy spells........ Y N
l. Hepatitis or other liver disease........ Y N
m. Tuberculosis (TB)........ Y N
n. HIV+ or AIDS........ Y N
o. Blood disorders (e.g. anemia, hemophilia)........ Y N
p. Kidney problems........ Y N
q. Stomach or intestinal problems........ Y N
r. Phobias, severe anxieties, depression, or other psychological problems........ Y N
s. Radiation, surgery, or chemotherapy to treat cancer........ Y N
t. Bleed excessively after being cut or receiving dental care........ Y N
u. Heart attack, stroke, or coronary bypass operation........ Y N
v. Shortness of breath after climbing 1 flight of stairs........ Y N
w. Pacemaker........ Y N
x. Pregnant or think you may be pregnant........ Y N
y. Breastfeeding........ Y N
z. Are there any other problems or issues about your health that you know of?........ Y N

If yes, explain______________________________

____

9. Have you ever taken medication (bisphosphonates) that affect the bone or to prevent bone disease (e.g. Fosamax, Zometa, Actonel, Aredia)?........ Y N

10. Have you ever been diagnosed with Sleep Apnea?........ Y N
11. Have you ever had an overnight sleep study?........ Y N
12. Do you or have you ever used a CPAP?........ Y N
13. Do you wake up in the mornings with headaches?........ Y N
14. Do you gasp for air at night?........ Y N
15. Do you snore?........ Y N

16. Are you currently taking any medications or substances, including over-the-counter, prescription, vitamin, or herbal products, for any reason? Please list below........ Y N

Medications:

____

____

____

____

____

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical or dental status to the dentist at the earliest time. I give permission to the dentist to obtain from my physician any additional information regarding my medical history needed to provide me the best dental treatment possible.

Signature:____ Date:_________________

If other than patient, please indicate relationship to patient:______________________________

Signature:____ Date:_________________

If other than patient, please indicate relationship to patient:______________________________

Signature:____ Date:_________________

If other than patient, please indicate relationship to patient:______________________________

Signature:____ Date:_________________

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Signature:____ Date:_________________

If other than patient, please indicate relationship to patient:______________________________

Signature:____ Date:_________________

If other than patient, please indicate relationship to patient:______________________________

Dr. Weston's and their staff would like to thank you for choosing our office for your dental needs. We look forward to providing you with exceptional dental care and working with you to achieve superior oral health!

SUMMERFIELD FAMILY DENTISTRY

APPOINTMENT POLICY & TELEPHONE POLICY

Your appointment at Summerfield Family Dentistry is important to us. Our scheduling time allows for your routine dental care and/or your dental treatment.

If you are unable to keep your reserved appointment, we ask that you contact our office within 48 hours. This courtesy allows our dental staff to provide other patients with the opportunity to come in for their treatment.

A broken appointment fee is applied if 48 hours is not given to our office. The fee is $1.00 per minute of the scheduled appointment missed. Certain exceptions may apply with the discretion of the dental office.

Thank you very much.

Signature ____

All telephone numbers provided by you may be subject to receiving telephone calls from an automated dialer using a pre-recorded, artificial voice message or live operator call. You give your prior express consent to receive such phone calls, including any calls made to your provided cellular telephone number.

Signature ____

Date____________________________________

Financial Policy for Summerfield Family Dentistry

We are dedicated to serving our patients with the highest quality of care. We ask that you help us keep our fees at a competitive level by paying your estimated balance at the time of services.

Your dental insurance plan represents a contract between you and the insurance company. As a courtesy we file the necessary paperwork to the insurance company to process your dental claims. We will accept the claim as partial payment for up to 60 days.

Payment in full is required at time of service if you do not have your dental card and we are unable to verify your benefit coverage. If you have a reimbursement plan payment in full is also required. These plans will reimburse you only.

We work diligently to provide you with as much information about your insurance coverage as possible, including deductibles, annual maximums, uncovered procedures and the amount of coverage allowed. Please understand that the insurance companies will not provide all information required to make allowed coverage estimates without some error. The information we provide is an estimate and the patient is responsible for any balance unpaid. All unpaid insurance balance beyond 60 days of treatment will become the responsibility of the patient. You will receive a statement.

We accept cash, debit cards, Visa, MasterCard and American Express. Please initial beside the financial arrangement option below that best meets your financial needs. You may change your selection for future procedures.

_____ Payment in full (5% courtesy allowance applied if paid with cash or check on amounts exceeding $500.00)

_____ Citi Health Group Finance Company or Care Credit (6 and 12 months interest free Finance options available)

I have read and understand the above policy.

______________________________ Patient Name

______________________________ Date

*There will be a $25.00 fee for all returned checks.
*All credits will be posted to your account.

Summerfield Family Dentistry

Notice of Privacy Practices Acknowledgment Form

____(print name)

I hereby acknowledge that I have reviewed the Notice of Privacy Practices from Summerfield Family Dentistry on ______________________(date)

____

Child's Name (minor)

____ ______________

Patient or Parent/ Legal Guardian Signature Date

I would like to allow access to the following people:

____

____

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