

FORREST & FORREST FAMILY DENTISTRY

M. BRAD FORREST & STACY OLLER FORREST, DMD, PA

WELCOME! THANK YOU FOR CHOOSING US AS YOUR DENTAL PROVIDER. OUR PRIMARY CONCERN IS THAT YOU RECEIVE THE BEST TREATMENT POSSIBLE TO MAINTAIN AND RESTORE YOUR OPTIMAL DENTAL HEALTH. PLEASE TAKE SOME TIME TO FILL OUT THE INFORMATION INCLUDED IN THIS PACKET. THIS IMPORTANT INFORMATION WILL HELP US SERVE YOU BETTER THROUGHOUT THE COURSE OF YOUR DENTAL CARE. IF YOU HAVE ANY QUESTIONS WE'LL BE GLAD TO HELP YOU. WE LOOK FORWARD TO WORKING WITH YOU IN MAINTAINING YOUR DENTAL HEALTH.

PATIENT INFORMATION (Confidential):

Date: ____/____/____

First Name _____ Middle Initial _____ Last _____
Preferred Name _____ Birth Date ____/____/____ SS# ____ - ____ - ____
Home Phone # _____ Work Phone# _____
Cell Phone # _____
Address _____ City _____ State _____ Zip _____
Employer _____ Business Address _____
City _____ State _____ Zip Code _____ E-mail Address _____
Where do you prefer to receive calls? Home Work Either
Spouse's Name _____ Employer _____ Wrk# _____
Emergency Contact _____ Relationship _____ Phone# _____
How did you hear about our practice? _____

PRIMARY DENTAL INSURANCE (Must be fill out completely in order to file your claim)

NOTE: **You** are responsible for any procedure **not covered** or **not paid** by your insurance.

Insurance Name _____ Phone# _____
Insurance Address _____
Employee Name _____
SSN# of Employee ____ - ____ - ____ Employee's DOB ____ - ____ - ____
Group# _____ Business/Employer Name _____
NOTE: **SUBSCRIBER ID#** (If Different from the SSN#): _____ Payor ID#: _____

PARENTAL INFORMATION (Please fill out completely if patient is a *minor*)

Father _____ Father's Address _____
Home Phone # _____ Work# _____ Cell# _____
Birth Date ____/____/____ SS # ____ - ____ - ____
Employer _____
Mother _____ Mother's Address (If different) _____
Home Phone # _____ Work# _____ Cell# _____
Birth Date ____/____/____ SS # ____ - ____ - ____
Employer _____
Who is financially responsible for this account? _____

DENTAL HISTORY

What would you like us to do today? _____
Are you in dental discomfort today? _____
Would you be interested in whitening your teeth? _____

If there is one thing that you would like to change about your smile, what would it be?

Former Dentist _____ Phone _____

Date of Last Dental Care _____ Date of last X-rays _____

Check (✓) if you have had problems with any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Grinding or clenching teeth | <input type="checkbox"/> Sensitivity to cold |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Sensitivity when biting | <input type="checkbox"/> Mouth Sores/Growth |

How often do you brush? _____ Floss? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?

YES NO If yes, explain _____

Other information about your dental health or previous treatment _____

MEDICAL HISTORY

Physicians Name _____ Phone# _____

Date of last visit _____ Have you ever had any serious illness or operations? YES NO

If yes, please describe _____

Are you currently under physician care? YES NO If yes, please describe _____

Have you ever had a blood transfusion? YES NO If yes, give approximate dates _____

Women: Are you pregnant? YES NO Nursing? YES NO Taking Birth Control Pills YES NO

Check (✓) if you have had any of the following:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis, Rheumatism |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergy Prone |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Cortisone Treatment | <input type="checkbox"/> Cough (persistent) |
| <input type="checkbox"/> Cough-up blood | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Heart Problems
<i>describe</i> | <input type="checkbox"/> Hemophilia/abnormal
bleeding | <input type="checkbox"/> Herpes | <input type="checkbox"/> Hepatitis |
| | <input type="checkbox"/> Kidney Disease or
Malfunction | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Material Allergies
i.e. latex, wool, metals,
chemicals - <i>describe</i> |
| <input type="checkbox"/> Pacemaker/Heart
Surgery | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Jaw Pain | |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Rheumatic/Scarlet Fever |
| <input type="checkbox"/> Rapid Weight Loss/Gain | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Skin Rash | <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Shingles | <input type="checkbox"/> Swelling of Feet or Ank | <input type="checkbox"/> Thyroid Disease or
Malfunction | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Surgical Implants | <input type="checkbox"/> Ulcer/Colitis | <input type="checkbox"/> Venereal Disease | |

List medications you are currently taking if any _____

List drug allergies if any: _____

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: _____ Date: _____

Forrest & Forrest Family Dentistry At Stevens Mill Crossing

Consent for Service

All dental services must be paid for in cash/credit card, in full, at the time services are performed. As a condition for your treatment by this office, financial arrangements for payment of services must be made in advance of your appointment by the patient.

I understand that insurance is a contract between the insurance company and the patient. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payments of all dental services at the time of service. It is the patient's responsibility to be aware of their own insurance benefits. This office will help prepare the patient's insurance forms as a courtesy; however, we do not guarantee any estimate of benefits or payment from the insurance company. We do use the latest technology to assist patients in filing claims to assure the most effective and timely reimbursement.

I understand that any fee estimate given by this office for any dental care can only be guaranteed for a period of ninety (90) days from the date of the patient examination.

We understand that there are situations when canceling your appointment is necessary. However, in the event that 2 (TWO) BUSINESS DAYS notice is not given, a charge of 25% OF THE SCHEDULED APPOINTMENT FEE will be applied to your account.

I grant my permission to you or your assignee, to telephone me at home or at any work to discuss matters concerning this information.

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

Date _____

Relationship to Patient

Signature of Guarantor of payment/Responsible Party _____

Payment for Your Dental Care

All dental services must be paid for in cash/credit card, in full, at the time services are performed. As a condition for your treatment by this office, financial arrangements for payment of services must be made in advance of your appointment by the patient. We offer several ways for you to plan for your treatment:

We accept cash, as well as, MasterCard, VISA, Discover, and American Express cards.

We offer a 5% senior citizens discount for patients who are at least 65 years of age.

We also offer financing plans through outside companies with no-interest and low-interest plans to qualified participants.

In the event there is a past due balance, a service charge of 11.5% per month (18%per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are made.

Please call if you have any questions. We will be glad assist you in any way we can.

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

Date _____

Relationship to Patient

Signature of Guarantor of payment/Responsible Party _____