Eastern Shore DENTAL CARE
BILLINGS • MURPHY

Medical History

Patient's Name:_____

Are you under a physician's care now? [ ] Yes [ ] No If yes, why?:_____

_____

Please list any medications you are taking: _____

_____

Are you allergic to any medications?:_____

Do you use tobacco: [ ]Yes [ ]No

Women: Are you: Pregnant/Trying [ ]Yes [ ]No Taking Oral Contraceptives [ ]Yes [ ]No Nursing [ ]Yes [ ]No

-PLEASE CHECK ANY CONDITIONS THAT APPLY TO YOU:

[ ]Heart Disease	[ ]Respiratory/Lung Disease	[ ]Kidney Disease
[ ]Heart Attack	[ ]Joint Replacement	[ ]HIV Positive/AIDS
[ ]Stroke	[ ]Diabetes	[ ]Hemophilia
[ ]Blood Thinners	[ ]Cancer	[ ]Stomach Ulcers
[ ]Pacemaker	[ ]Leukemia	[ ]Hepatitis A
[ ]Artificial Heart Valve	[ ]Thyroid Disease	[ ]Hepatitis B or C
[ ]Irregular Heart Beat/Arrhythmia	[ ]High Blood Pressure	[ ]Narcotics Addiction

Please list any other serious conditions not listed here:_____

_____

Dental History

Reason for your visit today: _____Date of last visit: _____

Date of your last dental exam/cleaning?: _____

Are you apprehensive about dental treatment? If so, why?_____

Are you happy with the appearance of your teeth?_____

Has any dental treatment been recommended but not received?:_____

What questions do you have for the doctor today?:

_____

Office Policies

Payment Policy: Payment for treatment is made on the day the service is rendered. For extensive treatment plans, payment plans are available and must be made before treatment is started.

Patients with insurance: Your co-payment is due on the day of service. We can only estimate your co-payment because insurance plans have so much variance. If your insurance company pays less than estimated, the additional co-payment is due at that time. If your insurance company has not paid for a service within 90 days, you will agree to pay the balance due in full at that time. If your insurance company pays you and not our office, you will be required to pay for our services when rendered.

Broken Appointments: A high number of broken appointments increase costs of delivering dental care for you and our other patients. With that in mind, we ask for at least 24 hours advance notice if you cannot keep your appointment. A $50 fee will be charged for a missed appointment with less than 24 hours notice.

Signature on file: I authorize Eastern Shore Dental Care to submit claim forms to my insurance carrier, and my signature below can take the place of an original signature on all submissions.

HIPPA Consent: I acknowledge receipt of this office's NOTICE OF PRIVACY PRACTICE.

Signed:_____ Today's Date:_____