

Intake Form

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, and maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. Our office does not use this information to discriminate.

Patient Information

Date (mm/dd/yyyy)	Date of Birth (mm/dd/yyyy)	Sex	Social Security Number	
Last Name		First Name	MI	
Address		City	State	ZIP
Mailing Address (if different)		City	State	ZIP
Home Phone	Cell Phone	Work Phone	E-Mail Address	
Preferred Methods to Confirm Appointments (Circle): Phone Text E-mail				Marital Status
Occupation		Employer		
Emergency Contact	Relationship	Home Phone	Cell Phone	

Responsible Party Information (if Patient is a Dependent)

Last Name		First Name	MI	
Address		City	State	ZIP
Relationship to Patient				
Home Phone	Cell Phone	Work Phone	E-Mail Address	
Social Security Number	Date of Birth (mm/dd/yyyy)	Employer		

Do you have dental insurance? Yes No If yes, who is your provider?

Primary Carrier	Policy Holder	Policy/Group Number	Subscriber ID
Secondary Carrier	Policy Holder	Policy/Group Number	Subscriber ID
Tertiary Carrier	Policy Holder	Policy/Group Number	Subscriber ID

Getting to Know You

How Did You Hear About Our Office?	
What Is The Reason For Your Visit?	
Is There Someone We Should Thank for Referring You?	
Is Another Member of Your Family Already a Patient With Us?	
When Was Your Last Dental Visit?	
When Was The Last Time You Had Complete Dental X-Rays?	
Have You Ever Had Teeth Removed?	How Long Have These Teeth Been Missing?
How Have These Teeth Been Replaced? (Circle) Bridge Partial Denture Implant Not Replaced	

FOR OFFICE USE ONLY - HEALTH HISTORY REVIEWED BY:

Signature

Date

Medical History

Patient Name	Date of Birth
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Are you under a physician's care now? Yes No If yes

Have you ever been hospitalized or had a major operation? Yes No If yes

Have you ever had a serious head or neck injury? Yes No If yes

Are you taking any medications, pills, or drugs? Yes No If yes

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics

Do you use controlled substances? Yes No If yes

Other? If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No			

Have you ever had any serious illness not listed Yes No If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature of Patient, Parent or Guardian	
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Signature

Date

Smile Survey

Do you like the way your teeth look?	Yes	No
Please Explain		
Are you happy with the color of your teeth?	Yes	No
Please Explain		
Would you like your teeth to be whiter?	Yes	No
Please Explain		
Would you like your teeth to be straighter?	Yes	No
Please Explain		
Do you have spaces between your teeth you would like closed?	Yes	No
Please Explain		
Do you have missing teeth you would like replaced?	Yes	No
Please Explain		
Do you like the shape of your teeth?	Yes	No
Please Explain		
Do you have old silver fillings you would like replaced with tooth colored?	Yes	No
Please Explain		
If you could change anything about your smile, what would you change?		
Please Explain		

Patient Name

Dental Insurance Policy

Barrett Family Dental proudly accepts most dental insurance plans. We file all dental insurance claims as a patient courtesy. In the event of a treatment plan, we create a reasonable estimate of patient co-payments and insurance contributions. This estimate is based on contracted insurance rates, the general breakdown of benefits obtained through the insurance verification process and our knowledge of common insurance practices. **This estimate is not a guarantee of insurance payment. All benefit determinations are at the discretion of the insurance company and are not determined until after a claim is submitted.** We provide treatment estimates as a courtesy in order to minimize the total out-of-pocket cost due by the patient. **All estimated co-payments are due at the time of service.**

Checks that are returned to our office by your financial institution are subject to a \$50.00 returned check fee. This fee covers the processing fees that are charge to our office for a returned check.

The Patient is responsible for any remaining account balance resulting from insurance nonpayment or underpayment. A statement will be mailed to you regarding this balance. Payment is due immediately upon receipt.

PATIENT ACKNOWLEDGEMENT AND AUTHORIZATON

I understand and agree to the Dental Insurance Policy stated above. I authorize all my insurance companies to make payment directly to Barrett Family Dental PC. This assignment will remain in effect unless revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance company. Further, I authorize the release of any patient information necessary to process these claims.

Signature

Date

Patient Name

Appointment Deposit Requirement

Barrett Family Dental requires a minimum \$50.00 deposit for all appointments requiring 90 minutes or more estimated chair time and for all appointments with a total treatment cost of \$500.00 or more. This deposit operates as a credit on the patient account towards the total patient portion due at the time of service. Barrett Family Dental requires this deposit because our providers and dental assistants reserve the appointment time specifically for you at the exclusion of other patients. **The deposit is subject to our Cancellation Policy.**

The deposit requirement is reserved only for those patients choosing not to pre-pay for their services in full when scheduling the appointment.

I understand and agree.

Signature

Date

Cancellation Policy

Barrett Family Dental makes an effort to see patients on time in order to give patients the care they deserve. Your scheduled appointment time is reserved for you. Therefore we ask that you **please give us 48 hours notice if you are unable to keep your scheduled appointment.** Failure to provide 48 hours notice or not showing up for an appointment is considered a “failed appointment.” **We reserve the right to charge a cancellation fee of \$50.00 for a failed appointment. We also reserve the right to dismiss any patient who fails two or more appointments.** We will make exceptions in the event of reasonable emergencies.

I understand and agree.

Signature

Date

Patient Name

*****You May Refuse to Sign This Acknowledgement*****

Acknowledgement of the Receipt of Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices dated September 13, 2018.

Signature

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, but acknowledgement could not be obtained because

- Individual Refused to Sign
- Communication Barriers Prohibited Obtaining the Acknowledgement
- An Emergency Situation Prevented Us from Obtaining Acknowledgement
- Other (Please Specify): _____

Staff Member Name

Staff Member Signature

Signature

Date