Health History

Moon Family & Cosmetic Dental

PLEASE PRINT

Name:	Birth Date:	Age:
Address:	Cell Phone:	Other:

The answers to the following questions will assist the dentist in evaluating your general health prior to providing your dental treatment. **Please read carefully and answer as accurately as possible.**

Please Circle any of the following which you have had or have at present:

Artificial Joint	Asthma	Cancer
Artificial Heart Valve	AIDS / AIDS related	Chemotherapy
Congenital Heart Disease	Anemia	Diabetes
Heart Murmur	Cold Sores frequently	Stroke
High Blood Pressure	Epilepsy / Seizures	Fainting / Dizzy
Frequent Chest Pains	Heart Disease/condition	Thyroid Disease
Hemophilia	Hepatitis	Tuberculosis TB
HIV Positive	Implant Prosthesis	Kidney Trouble
Liver Disease	Prolonged/unusual Bleeding	Radiation Treatment
Shortness of Breath	Sickle Cell Disease	

Do you have an artificial Joint? **Details:**	Yes	No
Do you need to take antibiotics prior to dental treatment? **Reason:**	Yes	No
Do you have any disease or condition not listed above?	Yes	No
Are you currently under the care of a physician?	Yes	No
Are you taking any medicine or drugs? **List and reason taking:**	Yes	No
Are you allergic to any medicine or materials? If yes, circle below & list reaction: **Penicillin** **Clindamycin** **Anti-inflammatory** **Narcotics** **Acrylic** **Metal** **Latex** **Sulfa Drugs** **List Other:**	Yes	No
Have you ever had a reaction to dental local anesthetic?	Yes	No
Have you ever had complications following dental treatment?	Yes	No
Have you ever been told you were not eligible to be a blood donor?	Yes	No
Do you use tobacco? Type: cigarettes – pipe- cigar – chewing – dip - snuff	Yes	No
WOMEN ONLY: Are you Pregnant or is there a chance you could be pregnant? Trimester?	Yes	No
Have you ever taken bisphosphonate or osteoporosis medications?	Yes	No
Would you like whiter teeth?	Yes	No
If you could easily change one problem with your teeth, what would it be?		

Dentist Comments:

Referred By:

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 patient's, health. It is my responsibility to inform the dental office of any changes in medical information every visit.

Signature of Patient/Legal Guardian (print name if guardian): **Date:**

Reviewers/date	**Reviewers/date**	**Reviewers/date**
Reviewers/date	**Reviewers/date**	**Reviewers/date**

Updated 4/19

WELCOME

We are pleased to welcome you to our practice.
Please complete this form, and provide any insurance cards.

PATIENT INFORMATION

Name_______________________________________ Soc. Sec. #____________________
Address____
City_________________ State______ Zip___________
Cell Phone________________________ Home Phone_____________________________
Email____________________________ Birthdate_______________________________
Single___ Married____ Widowed____ Separated____ Divorced____
Employer_____________________________ Occupation____________________________
Notify in case of emergency_____________________ Relationship____________________
Phone Number______________________________

PRIMARY DENTAL INSURANCE

Subscriber Name______________________________ Birthdate____________________
Employer____________________________________ Soc. Sec. #___________________
Insurance Company____________________________ Phone Number________________
Insurance Company Address____
City___________________ State_____________ Zip______________
ID Number_____________________
Group Number__________________

SECONDARY DENTAL INSURANCE

Subscriber Name______________________________ Birthdate____________________
Employer____________________________________ Soc. Sec. #___________________
Insurance Company____________________________ Phone Number________________
Insurance Company Address____
City___________________ State_____________ Zip______________
ID Number_____________________
Group Number__________________

I authorize the dentist to release all information necessary to secure payment of insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_________________________________ Date________________________
Print Name________________________________

FINANCIAL POLICY
FOR
MOON FAMILY & COSMETIC DENTAL

1. We accept a variety of dental insurance plans, and assist our patients in filing their claims as part of our service. However, **patients** are responsible for knowing the details of their individual contract, including benefits, limitations, and yearly maximum coverage.

2. Patients with dental insurance must have their benefits verified; and be prepared to pay deductibles and co-insurance at the initial appointment, as well as each subsequent appointment while under treatment.

3. Patients **NOT** covered by a dental insurance plan must pay in full for the visit at the time services are rendered. Payment methods include **Visa, MasterCard, Discover and Check. Checks returned for non-sufficient funds will incur a $35.00 return check fee**.

4. **In accordance with our office policy, we require 48-hour cancellation notice, if an appointment cannot be kept. Please be aware our office hours are Monday 7:30 a.m. to 12:30 p.m. and Tuesday thru Thursday 7:30 a.m. to 5 p.m.** ***A fee of $75 will apply for no-show/cancellation without two (2) full working days notice.*** A specific time is reserved for you and last minute cancellations result in a lost opportunity for another patient to receive dental care.

*** I understand that I am financially responsible for all treatment costs NOT covered by my dental insurance.**

Please sign below acknowledging that you understand and *agree* to these policies.

Signature____**Date**____________________

Print Name____

2/2021

Moon Family & Cosmetic Dental

Acknowledgement of Receipt of Notice Privacy Practices
(Patient Consent Form)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (**HIPPA**). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
2. Obtain payment from third party payers (e.g. my insurance company)
3. The day-to-day healthcare operations of your practice

I acknowledge that I have been informed of your Notice of Privacy Practices which contains a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree you are bound to abide by such restrictions.

Date________________

Print Patient Name________________________________

Relationship to patient_____________________________

Signature_______________________________________