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

- 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.

- 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. **If the insurance company denies a claim for any reason, this amount will become the patient's responsibility.**

- Patients **NOT** covered by a dental insurance plan are responsible for payment in *full* at the time service. We accept **Visa, MasterCard, Discover, AMEX, and personal checks.** There will be a charge of $35.00 for any check returned due to insufficient funds, plus any bank fees incurred including bank charge back fees.

- Please be aware our office hours are Monday 7:30 am. to 12:30 pm. - Tuesday thru Thursday 7:30 am. to 5:00 pm. ***A fee of $75.00 will apply for any no-show/cancellation without two (2) full working days notice.***

- Any account outstanding over 30 days, will incur a finance charge.

- All accounts must be **CURRENT** and in good standing before a new appointment will be scheduled.

Please sign below acknowledging that you understood the above mentioned policies.

Signature_____**Date**_____

Print Name_____

9/2023

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_____