Acree & Isenhower Family Dentistry

1213 Coffee Road, Ste. B Modesto, CA. 95355 - (209) 529-0674

Welcome

The benefits of a healthy smile are immeasurable! Our goal is to help you reach and maintain optimal dental health.

Please fill out our forms completely in black or blue ink.

1. ABOUT YOU

Today's Date:

Name:
Last *First* *MI* *MR.,MRS.,MS.,DR. (circle one)*

I prefer to be called: Male / Female *(circle one)*

Home Address:
STREET, APT/CONDO *CITY* *STATE* *ZIP*

Hm# Wrk# Ex# Cell# E-mail

SS #: Birthdate: Age:

Married *Single* *Divorced* *Widowed* *Separated* *(circle one)*

Employer: How long? *Yr./Mo.* Occupation:

Employer's Address:

Where & when are best times to reach you?

How were you referred to our office?

Are any family members patients in our office *(circle one)* Yes or No Name:

2. SPOUSE INFORMATION

His/Her Name: Birthdate: Age:

Employer:

Work #: Ext.#: SS #: Cell#

3. DENTAL INSURANCE

Primary Ins.

Insured's Name: Group # (Plan, Local or Policy #)

Insured's Birthdate: Relation:

Insured's Employer: Insured's SS #:

Insurance Co. Name: Insurance Co. Phone #:

Insurance Co. Address:

Secondary Ins.

Insured's Name: Group # (Plan, Local or Policy #)

Insured's Birthdate: Relation:

Insured's Employer: Insured's SS #:

Insurance Co. Name: Insurance Co. Phone #:

Insurance Co. Address:

4. EMERGENCY INFORMATION

In the event of an emergency, is there someone who lives near you that we should contact?

Name: Relation:

Work#: Ext.#: Home #:

Name of your Family Doctor: Phone #:

5. PERSON RESPONSIBLE FOR ACCOUNT

Name: Self - Spouse - Parent - Guardian

Work #: Ext.#: Home #:

Billing Address:

(see reverse)

Acree & Isenhower Family Dentistry
1213 Coffee Road, Ste B Modesto, CA 95355
Terms and Agreements

Patient Name: ______________________________

Release of health information:
The provider may disclose all or part of the patient's health record in accordance with the Health Insurance Portability and Accountability Privacy Rule (HIPAA) to facilitate patient treatment, healthcare operations or financial obligations. A copy of this office's HIPPA policy will be provided upon the patient's initial visit to the office.

Financial agreement, Assignment of benefits, Authorization for treatment:
I authorize treatment of the person named above and agree, irrevocably, whether signing as agent or patient, that in consideration of the services to be rendered to the patient that I hereby individually obligate myself to pay the account in accordance with the regular rates and terms of the provider. I hereby give authorization for payment of insurance benefits directly to the provider named above, and/or any assisting physicians for services rendered. *(A copy of this assignment is valid as original).*

I understand that my insurance will be billed by this office strictly as a courtesy and all charges are my responsibility to resolve. I agree that my payment will not be delayed or withheld because of any insurance coverage or payment of claim interruption. I understand that this practice is committed to providing the best treatment for it's patients regardless of an insurance company's arbitrary determination of usual and customary rates or treatment.

As required by law, I am hereby notified that a negative report may be submitted to a credit reporting agency if I fail to fulfill the financial terms of this agreement. Should my account be referred to an attorney or collection agency for collection proceedings, I, the undersigned agree to pay actual attorney fees and collection expenses in addition to balance owed this practice.

Acceptable methods of payment:
I am aware that payment is due at the time services are rendered unless both parties have agreed upon other arrangements. Acceptable forms of payment are cash, personal check and major credit cards.

Additional fees:
1.) A $25.00 fee in addition to the banking fee may be charged on all returned checks.
2.) 1.5% monthly finance charge will be assessed on all accounts not settled within a 60-day cycle after determination of patient responsibility.
3.) A $40.00 late cancellation or failed appointment fee may apply.

I understand and agree to the terms and agreements listed above. I certify to the best of my knowledge that my answers provided on the reverse side of this form are complete and accurate.

____

Patient or Parent/Guardian Signature Date

____

Provider Signature Date

Revised Jan 2013

Please complete in black or blue ink.

Acree & Isenhower Family Dentistry

Patient Name: ______________________________ **MEDICAL HISTORY**

Have you been under the care of a medical doctor during the past two years? YES NO

If yes, for what? ______________________________

Physician's Name ______________________________ Phone ______________

Address ______________________________ City ______________ State ______ Zip ______

Have you taken any medications or drugs during the past two years? YES NO

Are you currently taking any medications, drugs or pills now? YES NO

If yes, please list name and dosage:

Does your physician require you take antibiotic prior to dental treatment? YES NO

Are you aware of having an allergic (or adverse reaction) to any medication or substance? YES NO

If yes, please list name and dosage:

Have you ever had an adverse reaction to local anesthetic? YES NO

Have you ever taken Bisphosphonates (inhibits bone resorption)? YES NO

(ie: Fosamax, Actonel, Boniva)

Have you ever taken the diet drug Phen-Fen? YES NO

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Item			Item			Item		
1. Heart (Surgery, Disease, Attack)...	YES	NO	16. Ulcers or Tumors...........	YES	NO	31. Venereal Disease.............	YES	NO
2. Chest Pain....................	YES	NO	17. Diabetes...................	YES	NO	32. A.I.D.S....................	YES	NO
3. Congenital Heart Disease.........	YES	NO	18. Thyroid Problems...........	YES	NO	33. H.I.V. Positive.............	YES	NO
4. Heart Murmur.................	YES	NO	19. Glaucoma..................	YES	NO	34. Cold Sores/Fever Blisters......	YES	NO
5. High Blood Pressure...........	YES	NO	20. Emphysema...............	YES	NO	35. Blood Transfusion...........	YES	NO
6. Mitral Valve Prolapse............	YES	NO	21. Chronic Cough.............	YES	NO	36. Hemophilia.................	YES	NO
7. Artificial Heart Valve............	YES	NO	22. Tuberculosis...............	YES	NO	37. Sickle Cell Disease..........	YES	NO
8. Heart Pacemaker..............	YES	NO	23. Asthma....................	YES	NO	38. Bruises Easily..............	YES	NO
9. Rheumatic Fever..............	YES	NO	24. Latex Sensitivity............	YES	NO	39. Liver Disease................	YES	NO
10. Arthritis/Rheumatism.........	YES	NO	25. Allergies or Hives...........	YES	NO	40. Neurological Disorders........	YES	NO
11. Cortisone Medicine...........	YES	NO	26. Sinus Trouble...............	YES	NO	41. Epilepsy or Seizures..........	YES	NO
12. Stroke......................	YES	NO	27. Radiation Therapy...........	YES	NO	42. Fainting or Dizzy Spells.......	YES	NO
13. Diet (Special/Restricted).......	YES	NO	28. Chemotherapy..............	YES	NO	43. Nervous/Anxious............	YES	NO
14. Artificial Joints (hip, knee, etc.).	YES	NO	29. Cancer.....................	YES	NO	44. Psychiatric/Psychological......	YES	NO
15. Kidney Trouble..............	YES	NO	30. Hepatitis A, B, or C..........	YES	NO			

Do you have or have you had any disease, condition, or problem not listed?

If yes, please list:

____

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

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Parent/Guardian Signature ______________________________ Date ______________

HISTORY REVIEW:

Doctor Signature: ______________________________ Date ______________

Revised Jan 2013

Please complete in black or blue ink.

Acree & Isenhower Family Dentistry

Patient Name: ______________________________ **DENTAL HISTORY**

Welcome! *So that we may provide you with the best possible care please, complete both sides of this medical/dental history form. All information is completely confidential.*

What is the reason for your visit today? ______________________________

____

Date of Last Dental Visit ____________ Last Dental Cleaning ____________ Last Full Mouth X-rays ____________

What was done at your last dental visit? ______________________________

____

Previous Dentist's Name ______________________________ Phone ____________

Address ______________________________ City ____________ State______ Zip__________

How often do you have dental examinations? ______________________________

How often do you brush your teeth? ____________ How often do you floss? ____________

What other dental aids do you use? (Electric toothbrush, toothpick, etc.) ____________

Do you have any dental problems now? YES NO

If yes, please describe ______________________________

Are any of your teeth sensitive to:

Hot or Cold?	YES	NO
Sweets?	YES	NO
Biting or Chewing?	YES	NO
Have you noticed any odors or bad tastes?	YES	NO
Do you frequently get cold sores, blisters or any other oral lesions?	YES	NO
Do your gums bleed or hurt?	YES	NO
Have your parents experienced gum disease or tooth loss?	YES	NO
Have you noticed any loose teeth or changes in your bite?	YES	NO
Does food tend to become caught between your teeth?	YES	NO

If yes, where? ____________

Do you:

Clinch or grind teeth while awake or asleep?	YES	NO
Bite your lips or cheeks regularly?	YES	NO
Hold foreign objects with your teeth?	YES	NO
(pencils, pipe, pins, nails, fingernails)	YES	NO
Mouth breathe while awake or asleep?	YES	NO
Have tired jaws, especially in the morning?	YES	NO
Smoke/Chew tobacco?	YES	NO

Have you ever had:

Orthodontic treatment?	YES	NO
Oral surgery?	YES	NO
Periodontal treatment?	YES	NO
Your teeth ground or the bite adjusted?	YES	NO
A bite plate or mouth guard?	YES	NO
A serious injury to the mouth or head?	YES	NO

If so, please describe, including cause____________

____

Have you experienced:

Clicking or popping of the jaw?	YES	NO
Pain? (joint, ear, side of face)	YES	NO
Difficulty in opening or closing the mouth?	YES	NO
Difficulty in chewing on either side of the mouth?	YES	NO
Headaches, neck aches or shoulder aches?	YES	NO

Are you satisfied with your teeth's appearance?	YES	NO

What would you like to change?

____

Have you ever bleached your teeth?	YES	NO
Do you feel nervous about dental treatment?	YES	NO

If so, what is your biggest concern?

____

Have you ever had an upsetting dental experience?	YES	NO

If so, please describe:

____

Is there anything else about having dental treatment that you would like us to know? YES NO

If so, please describe ______________________________

____

(Please complete other side)

ACREE & ISENHOWER FAMILY DENTISTRY

DOWNEY PARK PROFESSIONAL CENTER
1213 Coffee Road, Suite B
Modesto, CA 95355
(209) 529-0674 - Fax (209) 529-1437

HIPAA Consent Form

Authorization to release medical information to other individuals.

Date:______________________________

Patient's Name:______________________________

Patient's Date of Birth:______________________________

Patient's Social Security Number:______________________________

I hereby authorize **Acree & Isenhower Family Dentistry** may release my Protected Health Information either verbally or in printed form to the following persons:

____
Name Relationship to patient

____
Name Relationship to patient

____
Name Relationship to patient

____
Name Relationship to patient

This authorization shall remain in effect until: ______________________________

____
Patient Signature Date Signed