Bringhurst Family Dentistry

Patient History

Today's Date:_________________

Patient Name:_________________________________ Sex: M/F Marital Status:__________

Address:_____________________________________ Social Security #:____________________

City:__________________ State:____ Zip:_______ Date of Birth:______________________

Spouse's Name:______________________________ If Child, Parent's Name:______________

Phone:__________________;__________________ Email:______________________________

Employer:____

Medical History

1. Who is your current family physician(s)?____
2. Have you been a patient in the hospital during the past two years? YES[ ] NO[ ]
3. Have you been under a physicians care during the past two years? YES [ ] NO [ ]
4. Have you been on any medication or drugs during the past year? YES [ ] NO [ ]
   a. If YES, please list:____
5. Are you ALLERGIC to any medication or drug? YES [ ] NO[ ]
   a. If YES, please list:____
6. DO YOU HAVE, OR HAVE HAD ANY OF THE FOLLOWING:

[ ] 7. Excessive Bleeding
[ ] 8. Heart Trouble
[ ] 9. Congenital Heart Lesions
[ ] 10.Heart Murmur
[ ] 11.High Blood Pressure
[ ] 12.Anemia
[ ] 13.Rheumatic Fever
[ ] 14. Radiation/Chemotherapy
[ ] 15.Asthma
[ ] 16.Chronic Chough
[ ] 17.Diabetes
[ ] 18.Tuberculosis
[ ] 19.Hepatits
[ ] 20.Jaundice
[ ] 21.Tumor/Growth
[ ] 22.Arthritis
[ ] 23.Stroke
[ ] 24. Epilepsy /Seizures
[ ] 25.Psychiatric Treatment
[ ] 26.Sinus Disease
[ ] 27.Veneral Disease
[ ] 28.Genital Herpes
[ ] 29.Stomach Disease/Ulcers
[ ] 30.Positive Test of HIV/AIDS
[ ] 31.Cancer
[ ] 32.History of Fainting
[ ] 33.Artificial Joints
[ ] 34.Other:__________________

35. Are you or do you think you could be pregnant? YES [ ] NO [ ] N/A [ ]

36. Are you in any dental PAIN? (Please Explain.)_____________________________________

____

Emergency Contacts-Please List Three

(Not living in your household)

Name:________________	Name:__________________	Name:___________________
Address:_______________	Address:________________	Address:_________________
______________________	________________________	_________________________
Phone:________________	Phone:__________________	Phone:___________________
Relationship:__________	Relationship:_____________	Relationship:______________

Who can we thank for referring you to our office?______________________________________

(MORE ON BACK)

Responsible Party Information

Person/Persons responsible for payment of the account

Applicant Information	*Joint Applicant Information*
Name:________________________________	Name:________________________________
Social Security:__________________________	Social Security:__________________________
Date of Birth:___________________________	Date of Birth:___________________________
Address:_______________________________	Address:_______________________________
City:______________ State:____ Zip:________	City:______________ State:____ Zip:________
Phone:_________________________________	Phone:_________________________________
Present Employer:_________________________	Present Employer:________________________

Financial Policy

Bringhurst Family Dentistry is committed to providing you with the best possible care; and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions regarding our fees, Financial Policy or your responsibility.

- **ALL PATIENTS MUST COMPLETE OUR PATIENT HISTORY FORM BEFORE SEEING THE DOCTOR.**
- **FULL PAYMENT IS DUE AT THE TIME OF SERVICE, UNLESS SPECIFIC PAYMENT ARRAGEMENTS HAVE BEEN MADE WITH THE BUSINESS OFFICE MANAGER.**
- **FINANCING IS AVAILABLE THROUGH CARE CREDIT.**
- **WE RESERVE THRE RIGHT TO CHARGE 0.85% INTREST PER MONTH, COMPOUNDED MONTHLY, ON ALL ACCOUNTS THAT ARE NOT PAID IN FULL WITHIN 90 DAYS FROM THE DATE OF SERVICE.**

REGARDING INSURANCE

If you have insurance, we will help you receive maximum benefits. Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will file insurance as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, “usual and customary charges”, ect; Other than to apply factual information as necessary. You are responsible for all charges and the timely payment of your account.

MEDICAID/WORKERS COMPENSATION

If you are covered by Medicaid, Workers Compensation, or any other government sponsored program, please discusses your payment situation with our office prior to service.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I authorize Bringhurst Family Dentistry to make whatever inquires it deems necessary in connection with this credit application. I further authorize any persons with a Consumer Reporting Agency to complete and furnish to Bringhurst Family Dentistry any information that it may have or obtain in response to such inquires , and agree that such information, *along with this application, shall remain the property of Bringhurst Family Dentistry, whether or not credit is extended.* All information stated in this application is declared to be true representation of the facts and made for the purpose of obtaining the credit requested.

____________________________________ ____________________________________

Applicant Signature Joint Applicant Signature