Moss Family Dental
PATIENT INFORMATION FORM

First Name ____________________ Middle Name ____________________ Last Name ____________________
Address ____________________ City ____________________ State ______ Zip ____________________
Date of Birth _____/_____/_____ Marital: **S M D W** Sex: **M F** Email ____________________
Referred by ____________________
How would you like to receive appointment reminders? (Please circle one) Voicemail Text Message Email
Home Phone: ____________________ May we leave a message at this number? **Yes No**
Cell Phone: ____________________ May we leave a message at this number? **Yes No**
Emergency Contact ____________________ Relationship ____________________ Phone ____________________

PERSON RESPONSIBLE FOR ACCOUNT

Name ____________________ Relationship to patient ____________________ Soc. Sec.# ____________________
Address ____________________ City ____________________ State ______ Zip ____________________
Phone ____________________ May we leave a message? **Y N** Employer ____________________

PRIMARY DENTAL INSURANCE INFORMATION

We are *Out of Network* with all insurance companies. *Co-pay is due the time of appointment.*

Policyholder's Name ____________________ Policyholder's Date of Birth _____/_____/_____
Relationship to Patient ____________________ Policyholder's Employer ____________________
Insurance Company Name ____________________ Policyholder's Subscriber ID ____________________
Group Number ____________________

SECONDARY DENTAL INSURANCE INFORMATION

Policyholder's Name ____________________ Policyholder's Date of Birth _____/_____/_____
Relationship to Patient ____________________ Policyholder's Employer ____________________
Policyholder's Soc. Sec. # ____________________ Insurance Company Name ____________________

Regarding Dental Insurance: It is important that we inform you that our services are charged to the patient, not an insurance company. As a courtesy we will send all charges to your insurance company. Dental insurance pays only a portion of your investment, and we urge you to be aware of the provisions of your policy.

MEDICAL HISTORY

Medical Doctor's Name: ____________________ **Date of last physical exam:** ____________________
Date of last dental exam(for new patients): ____________________ **Preferred Pharmacy:** ____________________
Current Medications including any supplements: ____________________

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Surgical History: ____________________

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Have you ever had any of the following? (Continued on next page)

Anemia	**Clotting Disorder**	**Heart Condition**	**Joint Replacement**	**Renal Insufficiency**
Autoimmune Disorder	**Cough (Persistent)**	**Hepatitis**	**Latex Allergy**	**Respiratory Disorder**
Blood Transfusion	**Currently Pregnant**	**Herpes**	**Migraines**	**Rheumatic Fever**
Cancer	**Diabetes**	**High Blood Pressure**	**Pacemaker**	**Stroke**
Chemical Dependency	**Epilepsy**	**HIV/AIDS**	**Radiation Treatment**	**Tuberculosis**

Do you have any allergies or reactions to any drugs, medications, or anesthetics? ____________________

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Any other conditions to be aware of? Please list: ____________________

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AUTHORIZATION & CONSENT FOR TREATMENT

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The finance charge will be a periodic rate of 1.5% per month, after 90 days. This is an annual percentage rate of 18% applied to the last month's balance. I understand that failure to pay will result in the use of legal representation and that I will be responsible for all fees incurred. The information on this page and the medical history are correct to the best of my knowledge. I understand that if I cannot attend my appointment, I will give 48 hour notice, or there may be a minimum of $50 charge. I hereby agree to the above terms.

Signature of Responsible Party:______________________________________Date: ___________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You may refuse to sign this acknowledgement

I, ______________________________, am the personal representative and have legal authority to make health care decisions about the following patient:

Patient Name:____

Authorized Representative (please print)____

Signature____**Date**__________________________________

AUTHORIZATION FOR ADDITIONAL DISCLOSURE

I authorize the following individuals to have access to my health information.

Name: Relationship:

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FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

______Individual refused to sign

______Communication barriers prohibited obtaining acknowledgement

______An emergency situation prevented us from obtaining acknowledgement

______Other (Please Specify) ____