

Ballentine & Bradshaw Family Dentistry

New Patient / Update Patient Form

Patient Information

First Name: _____ Last Name: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Birth Date: _____ Drivers Lic: A copy will be made of license SS No: _____

Sex: Female Male Marital Status: Married Single Divorced Separated Widowed

Preferred Pharmacy: _____ Preferred Doctor/Hygienist: _____

Emergency Contact Person / Phone: _____

Responsible Party / Guarantor (if someone other than patient)

First Name: _____ Last Name: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Birth Date: _____ Drivers Lic: _____ SS No: _____

Dental Insurance Information

	Primary Insurance	Secondary Insurance
Name of Insured		
Relationship to Pat.		
Insured Birth Date		
Insured SS No		
Employer		
Address		
City, State, Zip		
Insurance Company		

Dental History

Date of last dental care: _____ Date of last x-rays: _____

Former Dentist: _____ Address: _____

Check if you have any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to cold |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or periodontal treatment | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Broken fillings | <input type="checkbox"/> Sensitivity to biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sores or growths in mouth | <input type="checkbox"/> Sensitivity to sweets |

Other: _____

Medical History

Are you under a physician's care currently? Yes No Date of last visit: _____

Physician's name: _____ Address: _____

Have you had any serious illnesses or operations? Yes No If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, approximate date: _____

Women – Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

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Check ✓ if you have any of the following:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone treatments | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Shortness Of Breath |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cough Up Blood | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Downs Syndrome | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stents |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental Health Disorder | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Aspergers Syndrome | <input type="checkbox"/> Fainting | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Swelling Feet/Ankles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Autoimmune | <input type="checkbox"/> Headaches | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Radiation | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Herpes | <input type="checkbox"/> Scarlet Fever | |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> High Blood Pressure | | |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Other: _____ | | |

Check ✓ if you utilize any of the following:

- | | | | |
|----------------------------------|---------------------------------------|------------------------------------|----------------------------------|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> CBD | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Tobacco |
| <input type="checkbox"/> Vaping | <input type="checkbox"/> Other: _____ | | |

List all medications you are taking _____

Are you allergic to any of the following:

- | | | | |
|----------------------------------|----------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Acrylic | <input type="checkbox"/> Codeine | <input type="checkbox"/> Local anesthesia | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Latex | <input type="checkbox"/> Metal | <input type="checkbox"/> Sulfa |

Other: _____

Signature

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform the dentist if I, or my minor child, ever have a change of any information (medical, insurance, contact information, etc)

Signature of Patient / Parent or Guardian

Date

Patient Acknowledgment and Consent Form

Effective April 14, 2003, the new federal law known as the Health Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future

To comply with one of HIPAA's requirements, we are making available to you our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

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entire patient portion is normally due when treatment is started. Any special financial arrangements must be made prior to start of treatment, with the appropriate doctor. Our office submits insurance claims to insurance companies for patient convenience and does not assume responsibility for the processing of such insurance claims or failure of insurance to pay for any reason. Estimated or pre-authorized insurance benefits are not guaranteed. Patient/Guarantor agrees to promptly pay on demand, any balance not paid by insurance. Patient/Guarantor shall pay all costs incurred by Ballentine & Bradshaw Family Dentistry relating to collection of any unpaid or delinquent balances (including, without limitation, attorneys and collection agency fees, court costs, paralegals) whether or not suit is filed. Ballentine & Bradshaw Family Dentistry reserves the right to terminate or deny any treatment if the patient's account is delinquent.

I have read the above Financial Responsibility Policy, I understand and agree with it.

Patient or Guardian Signature	Date
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Cancellation / No Show Office Policy

Appointment cancellation and no show policy: Our policy requires at least 24 hour notice for all cancelled appointments. There is a charge of \$30.00 for all appointments not cancelled with a 24 hour advanced notice. In the instance that there is a charge on your account for a missed appointment, payment must be made prior to the next visit. Three (3) no shows within one year, may result in a discharge from the practice.

I have read the above Cancellation / No Show Policy, I understand and agree with it.

Patient or Guardian Signature	Date
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