Patient Information

First Name: _____ Middle Initial: _____ Last Name: _____

Preferred Name (if different than first name): _____

Address: _____

City: _____ ST: _____ Zip: _____

Sex: M_____ F_____ Marital Status: M_____ D_____ S_____ W_____

Birth Date: _____/_____/_____ Social Security: _____/_____/_____

Cell Phone: _____ Alternate Phone: _____

Email Address: _____

How Did You Hear About Us: _____

Insurance Information

Insurance Company: _____

Subscriber: _____

Subscriber ID: _____

Group Number: _____

Subscriber DOB: _____

Employer: _____

Emergency Contact

Name: _____

Relationship: _____

Phone Number: _____

Cancellation Policy: I acknowledge that I am responsible to give a **MINIMUM** of 24 hours' notice to cancel or reschedule any appointment. Failure to do so will result in a $50 missed or broken appointment fee and/or refusal to reschedule my appointment until the account is settled in full.

Initials:

Credit Card Processing Fees: Blacklick Creek Dental charges a 3.5% processing fee on **ALL Debit and Credit Card** transactions **except** Health Savings Accounts.

Initials:

Medical History

Name: _____ Date: _____

How often do you brush? _____ How often do you floss? _____

Do you like your smile? Y N What would you change about it? _____

Are you currently in pain: Y N Chief Concern _____

Check all that apply:		
○ Adverse reaction to dental anesthetics	○ Food Collection between teeth	○ Sensitivity to Hot / Cold
○ Bad breath	○ Grinding/Clenching	○ Sensitivity to Sweets / Chewing
○ Bleeding gums	○ Heartburn or Acid Reflex	○ Sores in Mouth
○ Broken Teeth/Fillings	○ Loose Teeth	○ Snoring or Tossing/ Turning or Restless Sleep
○ Clicking or Popping of Jaw	○ Periodontal Disease	○ Tonsillitis

(Women) Are you Pregnant: Y N Nursing: Y N Taking Birth Control Pills: Y N

Are you Currently Taking: (Please Circle)			
Y N ASPIRIN Y N PLAVIX Y N COUMADIN/WARFARIN	○ Back Problems ○ Cancer ○ Chemical Dependency ○ Chemotherapy ○ Dementia ○ Diabetes ○ Difficulty Breathing ○ Epilepsy ○ Facial Jaw Surgery ○ Fainting ○ Head aches ○ Heart attack	○ Heart Murmur ○ Hemophilia ○ Hepatitis ○ High Blood Pressure ○ HIV /AIDS ○ Jaw Pain ○ Joint Replacement ○ Kidney Problems ○ Liver Diseases ○ Low Blood Pressure ○ Psychiatric Conditions ○ Radiation Therapy ○ Rheumatic fever	○ Scarlet Fever ○ Seizures ○ STD's ○ Shingles ○ Sinus Problems ○ Stroke ○ Thyroid Problems ○ Tuberculosis ○ Ulcers ○ Mitral Valve Prolapse ○ Pacemaker ○ Other _____ _____
Check all that apply: ○ Abnormal Bleeding ○ Anemia ○ Arthritis ○ Asthma ○ Artificial Bones			

FAMILY HISTORY (Please Circle)

Cancer Diabetes Heart Attack High Blood Pressure Periodontal Disease Sleep Apnea

Medications **Please list medications you are taking:**	**Allergies (Please Circle)**		Latex Metals Other
_____ _____ _____ _____ _____	Y N Y N Y N Y N Y N Y N	Aspirin Codeine Anesthetics Erythromycin Penicillin Sulfa Drugs Tetracycline	_____ _____ _____ _____

Name: _____ Date: _____

Financial Agreement

* For my convenience, Blacklick Creek Dental may release my information to my insurance company and receive payment directly from them.
* If my account is sent to collections, I agree to pay all related collections fees and court costs.
* Every effort will be made to help me with my insurance claims, however, if the insurance company denies the claim, I am financially responsible for the **Full Fees** to Blacklick Creek Dental.
* I agree to pay finance charges of 1.5% per month (18% APR) on **ANY** balance more than 90 days past due.
* I agree to pay a fee of $50 for appointments broken without a **MINUMUM** of 24 hours' notice.
* Should my treatment plan change, I am be financially responsible for the services rendered.

Signature: _____ Date: _____

Notice of Privacy Policies

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke this permission, but must do so in person in writing.

Signature: _____ Date: _____