Taylorsville Family Dental Inc.

Joseph White III, DDS

PATIENT AGREEMENT

We are committed to providing you with the highest quality dental care using only the best material and technology available. We are also committed to providing you with up to date information and educational tools so that you may fully participate in maintaining optimal oral health. This agreement is intended to facilitate excellent service to you while minimizing our administrative costs.

Your cost for treatment is due at the time service is provided. Our office accepts cash, personal checks and most major credit/debit cards. Financing programs for larger treatment plans are available through our office or through CareCredit.

If you are a patient with dental insurance, we require you to sign this agreement. This instructs your insurance carrier to send payment directly to our office. Refusal to sign this form will result in your treatment being paid at the time of service and you billing your insurance company on your own.

Although we are willing to complete and submit insurance forms on your behalf, we do not accept responsibility for the outcome of the claim. Filing the dental claim is a courtesy we extend to you in an effort to save you time and to facilitate payment to our office. All charges you incur are your responsibility regardless of insurance coverage. If payment from your insurance company is not received within 60 days from the date of service you may be expected to pay the balance in full immediately.

Your estimated co-payment for treatment, which is the amount not covered by insurance, is due at the time we provide service to you. The co-payment amount is only an estimate and a different amount may actually be due once the actual insurance payment is applied to your account.

Returned checks will incur a minimum $35 insufficient funds fee. Balances older than 30 days are subject to finance charges and possible collection fees.

When you schedule an appointment in our office you are reserving time especially for you and your dental needs. We require at least 24 hours notice when cancelling/rescheduling and appointment. This policy allows us to be able to offer that time to someone else in need. Failure to give us that courtesy may result in a charge or a dismissal from the practice.

If you have any questions regarding this agreement, please ask. Our front desk staff will be happy to assist you. Our goal is to exceed your expectations for the most positive experience in dental care.

I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THIS AGREEMENT. IF THERE IS INSURANCE, I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO JOSEPH WHITE III, DDS AT TAYLORSVILLE FAMILY DENTAL.

PRINT PATIENT NAME_____ DATE_____

_____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

7212 Taylorsville Rd ▪ Huber Heights, OH 45424 ▪ 937-233-6500
www.TaylorsvilleFamilyDental.com

Taylorsville Family Dental Inc.

Joseph White III, DDS

PROTECTED HEALTH INFORMATION CONSENT

I give this practice, Taylorsville Family Dental, my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction.

I also understand that I may revoke this consent at any time, by making a request in writing. This will not apply to information already used or disclosed for treatment completed prior to the revocation.

Signature:_____ Date:_____
Patient, parent or legal guardian

If signed by patient representative, state relationship to patient:_____

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PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____ (PLEASE PRINT) Home Phone (____)_____

Patient _____
Last Name First Name Middle Initial Preferred Name

Street Address _____ City_____ State _____ Zip_____

E-mail_____ Cell Phone (____) _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years

Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Spouse/Parent Name _____ Spouse/Parent Birthdate _____

Spouse/Parent Employed by_____ Occupation _____

Business Address _____ Business Phone (____) _____

Who is responsible for this account?_____ Relationship to Patient _____

Social Security #_____ Spouse/Parent's Social Security # _____

Name of Dental Insurance Company _____ Group Number_____

In case of emergency, who should be notified?_____ Phone (_____) _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name_____ Date of Last Physical_____

Have you ever had any of the following? (check boxes that apply):

☐ Allergies
☐ Arthritis
☐ Artificial Heart Valves or Joints, Screws, etc
☐ Back Problems
☐ Bleeding Abnormally
☐ Blood Disease
☐ Cancer
☐ Chemical Dependency
☐ Chronic Diarrhea
☐ Circulatory Problems
☐ Congenital Heart Lesions
☐ Diabetes
☐ Epilepsy
☐ Headaches
☐ Heart Murmur
☐ Heart Problems
☐ Hemophilia
☐ Hepatitis, Jaundice or Liver Disease
☐ Hernia Repair
☐ High Blood Pressure
☐ HIV/AIDS
☐ Low Blood Pressure
☐ Mitral Valve Prolapse
☐ Nervous Problems
☐ Pacemaker
☐ Psychiatric Care
☐ Radiation Treatment
☐ Recent Weight Loss
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Sinus Problems
☐ Special Diet
☐ Stroke
☐ Swollen Neck Glands
☐ Ulcer
☐ Venereal Disease

Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia? ☐ Yes ☐ No

If so, what?_____

Have you ever responded adversely to medical or dental treatment? ☐ Yes ☐ No

Are you taking any medication at this time?_____ If so, what?_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) ☐ Yes ☐ No

Are you under the care of a physician? ☐ Yes ☐ No For what conditions? _____

If patient is a child, what is his/her weight? _____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Due date _____

Are you nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Is there anything else we should know about your medical history? _____

_____

CERTIFICATION

To the best of my knowledge, the information I have provided on this form is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Parent, Guardian or Personal Representative ______________________ Date ______________

Please print name of Parent, Guardian or Personal Representative ______________________ Relationship to Patient ______________

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________

Is the patient taking any new medications? ______________ If so, what? ______________________

Date ______________ Patient Signature ______________________

Date ______________ Dentist Signature ______________________

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________

Is the patient taking any new medications? ______________ If so, what? ______________________

Date ______________ Patient Signature ______________________

Date ______________ Dentist Signature ______________________

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________

Is the patient taking any new medications? ______________ If so, what? ______________________

Date ______________ Patient Signature ______________________

Date ______________ Dentist Signature ______________________

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________

Is the patient taking any new medications? ______________ If so, what? ______________________

Date ______________ Patient Signature ______________________

Date ______________ Dentist Signature ______________________