HAWS FAMILY DENTISTRY

MEDICAL HISTORY

Patient's Name _____ Date of Birth _____
(Please print name)

Medical Doctor _____ Doctor's Phone: _____
(First and last name, please)

1. Have you been a patient in a hospital during the past year? . . . . . YES NO
2. Have you been under the care of a physician during the past year? . . . . . YES NO
3. Date of last medical exam: _____
4. Are you taking any of the following drugs: (Circle and explain.)

Antibiotics	Steroids	High Blood Pressure meds
Tranquilizers	Anticoagulants (blood thinners)	Insulin or similar
Heart Medications	Aspirin	Hormones
Others: _____		

5. Are you allergic to any medicine or drugs? If so, please list: _____
6. Have you ever had excessive/prolonged bleeding requiring special treatment? . . . . . YES NO
7. Have you had any adverse reaction to local anesthetics? . . . . . YES NO
8. WOMEN ONLY! Are you pregnant? If YES, how many months? _____ . . . . . YES NO
9. CIRCLE any of the following which you have at present or have had:

Hepatitis	Pacemaker	Heart Attack	Thyroid Disease	Liver Disease
Heart Surgery	Coronary Artery Disease	Cortisone Treatment	Jaundice (other than infant)	
Artificial Joint	Arteriosclerosis	Allergies	AIDS/HIV+	X-Ray Therapy
Hardening of Arteries	Latex Allergy	Tuberculosis	Cobalt Therapy	High Blood Pressure
Asthma	Rheumatic Fever	Leukemia	Heart Failure	Arthritis
Heart Defect	Hemophilia	Stroke	Rheumatism	Artificial Heart Valve
Anemia	Diabetes	Epilepsy	Heart Murmur	Heart Disease
Kidney Trouble/Disease	Seizures/Dizzy Spells	Any disease/condition/problem not listed: _____		

10. Do you require antibiotic premedication for a heart condition, artificial valve or artificial joint? . . . . . YES NO
11. Have you ever had an unusual reaction or are you allergic to any of the following drugs? . . . . . YES NO

    Penicillin _____; Aspirin _____; Acetaminophen _____; Ibuprofen _____; Codeine _____; Barbiturates _____; Sulfa Drugs _____;
    Other _____

12. Are you subject to fainting? . . . . . YES NO
13. Do you have any allergies? If so, please describe: _____ YES NO
14. Have you ever had a nervous breakdown or undergone psychiatric treatment? . . . . . YES NO
15. Have you ever received counseling for excessive use of alcohol and/or prescription drugs? . . . . . YES NO
16. Are you having dental pain or discomfort at this time? . . . . . YES NO
17. Do you feel very nervous about having dental treatment? . . . . . YES NO
18. Do you use tobacco? If YES, what type and how much per day? . . . . . YES NO
19. When did you last have dental work? _____ Did they take x-rays? . . . . . YES NO
20. Teeth cleaned? _____
21. What type of toothbrush do you use? (soft, medium, hard, electric) _____
22. How often do you brush? _____ Floss? _____
23. Who was your previous dentist? _____
24. Do you think that your teeth are affecting your general health in any way? . . . . . YES NO
25. Do you have or have you ever had bleeding or sensitive gums? . . . . . YES NO

The above information is true and correct to the best of my knowledge.

ADULT (18 years and older)

_____
Patient's Signature

_____
Date

MINOR (and other dependents)

_____
Signature of minor patient's parent/guardian

_____
Relationship to patient/Authority to give consent

CONSENT TO PROCEED

I authorize Dr. Jayson Haws and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual or which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness; and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of dental treatment, including preventive procedures such as cleanings, and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. After lengthy appointments, jaw muscles may also be sore or tender. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases sutures or additional treatment may be required.

I understand that as part of dental treatments items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name: _____

Signature: _____ Date: _____
(Patient, legal guardian or authorize agent of patient)

Witness: _____

HAWS FAMILY DENTISTRY

Patient's Name_____Driver's License #_____

Address _____City/State_____Zip _____

Home Phone_____Cell Phone_____Work Phone_____

Patient's SS #_____ Sex: M _____ F _____ Marital Status: M____ S____ W____ D____

Patients' Email Address _____ I would like to receive info by email: YES NO

Patient's Employer_____City/State _____

Parent/or Spouse's Name_____Parent/or Spouse's SS #_____

Parent/or Spouse's Date of Birth_____Work Phone_____ Cell Phone_____

Parent/or Spouse's Employer_____

Emergency Contact_____Relationship to Patient_____

Phone #_____Address_____

How did you hear about our office? Internet____Facebook____Patient Referral____Name_____

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT

Name of responsible party_____Date of Birth_____

Address _____City/State_____Zip Code_____

Home Phone_____ Cell Phone_____SS #_____

Email Address_____Driver's License #_____

Employer_____ Work Phone_____

Employer's Address_____City/State_____Zip_____

Will dental insurance be involved? YES NO Name of Insurance Co. _____

Will secondary insurance be involved? YES NO Name of Insurance Co. _____
If yes, please have your identification card available so we may make a copy.

METHOD OF PAYMENT

☐ Payment in full at each appointment (cash, check or credit card)

☐ Care Credit

My mobile number is_____. I authorize the use of my mobile phone number (previously listed) to receive scheduling and billing messages. I agree to update this office if my mobile number changes. (Please initial)_____

Signature _____ Date _____
Patient or Responsible Party

OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangement must be made in advance. The practice depends upon reimbursement from our patients for the cost incurred in their care to remain viable and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental service performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

As a courtesy to our patients with insurance, we will file your dental claims for services rendered. You are responsible for paying any deductible, copayment, and patient portion at the time of service. Our office staff makes every effort to be as accurate as possible when collecting these amounts; however, your insurance plan may not cover as much as we estimate. After 45 days if your insurance has not paid, the remaining balance becomes your responsibility and you will need to seek reimbursement from your insurance company. You will be given 45 days to pay your balance in full before your account is sent to collections.

A service charge of 2% per month (24% per annum) on the unpaid balance will be assessed on all accounts exceeding sixty days from the date of service unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request for my minor child or ward by the dentist, I agree to pay, therefore, the reasonable value of said services to said dentist or his assignee at the time said services are rendered within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition. Should my account be turned over for collections, I agree to pay all costs to collect the debt, including, but not limited to, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party collections agency. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc, to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

A $50 fee may be applied following a broken appointment with less than 48 hour notice. Rescheduling or cancelling with greater than 48 hour notice will not result in a broken appointment fee.

I grant my permission to you or your assignee to telephone me at my workplaces to discuss matters related to this form.

This agreement supercedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial agreements or quality of care are null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or paper form to my insurance carrier or any related entities that require such information to be submitted.

I certify that I have read and agree to this financial policy. I hereby agree to abide by the conditions outlined herein.

_____	_____	_____
Signature of Patient, parent or guardian	Date	Relationship to patient
_____	_____	
Witness	Date	