BOYD
FAMILY DENTISTRY

Please read and initial the following:

Initial

- For each appointment, we reserve a patient room, your records and insurance is pre-checked and special instruments are prepared. Due to the preparation time involved, please give at least 48-hours notice to change or cancel your appointment. _____

- We ask that you pay any deductible or co-pay at the time of service. _____

- If you have insurance, we will do our best to accurately **estimate** your out-of-pocket expenses. However, the insurance company reserves the right to pay a different portion or deny payment of any claim. Please know that you are responsible for any charges your insurance does not cover for each procedure. _____

- Please notify us if you have secondary dental insurance. As a courtesy to you we process secondary dental claims and make every effort to ensure an accurate estimate of your out-of-pocket cost. Please note that some secondary dental insurance may deny payment if primary insurance pays any portion of a claim. _____

- Insurance companies require your authorization for Boyd Family Dentistry to receive payments from your insurance company. Your signature below authorizes direct payment to M. Austin Boyd DMD P.C. from your insurance company. _____

- **I have thoroughly read and understand the above conditions of payment and treatment and agree to these conditions.** _____

Patient/Guardian Signature: _____ Date_____

Scanned into EDR:

_____

FOR OFFICE USE ONLY

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Patient Information:

Patient Name: _____

Preferred Name: _____

Sex: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑Widowed

Birthdate: _____

Patient's SSN: _____

DL #: _____

Mailing Address: _____

_____

Email Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Text me appointment reminders ❑ yes ❑ no

Insurance Information:

Primary Insurance:

Policy Holder's Name: _____

Employer: _____

Insurance Company Name: _____

Policy Holder's SSN: _____

Policy Holder's Date of Birth: _____

Group #: _____

Contract #: _____

Secondary Insurance:

Policy Holder's Name: _____

Employer: _____

Insurance Company Name: _____

Policy Holder's SSN: _____

Policy Holder's Date of Birth: _____

Group #: _____

Contract #: _____

What brings you to our office today? _____

How did you learn about us? _____

Do you feel nervous about having dental treatment done? _____

Do your gums ever hurt or bleed when you brush/floss? ❑ yes ❑ no ❑ unsure

Do you grind your teeth? ❑ yes ❑ no ❑ unsure

Emergency Contact Information:

Name: _____ Relationship: _____ Phone Number: _____

Acknowledgement of Privacy Practices: I have been offered/read/received if requested a copy of the Notice of Privacy Practices. (Laminated copy available at the front counter. Paper copy upon request.)

Patient/Guardian Signature: _____ Date: _____

BOYD FAMILY DENTISTRY

Medical Health History

Please check all that apply:

- ❑ Do you pre-med for dental procedures?
- ❑ Abnormal bleeding after extractions or surgery
- ❑ AIDS or HIV positive
- ❑ Alcoholism
- ❑ Allergies or sinus problems
- ❑ Anemia or blood disorders
- ❑ Arthritis
- ❑ Artificial joint or valve replacement
- ❑ Asthma
- ❑ Blood transfusion
- ❑ Blood thinners List: _____
- ❑ Cancer
- ❑ Chewing tobacco
- ❑ Cold sores
- ❑ Diabetes
- ❑ Drug abuse
- ❑ Emotional condition
- ❑ Epilepsy
- ❑ Epinephrine problems
- ❑ Fainting spells
- ❑ Heart condition Type: _____
- ❑ Hepatitis
- ❑ Liver disease
- ❑ Venereal Disease
- ❑ High blood pressure
- ❑ Kidney disease
- ❑ Low blood pressure
- ❑ Migraine headaches or frequent headaches
- ❑ Neurologic condition
- ❑ Pacemaker
- ❑ Radiation treatment
- ❑ Rheumatic fever
- ❑ Seizures
- ❑ Sleep Apnea
- ❑ Smoker
- ❑ Steroid treatment
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ TMJ
- ❑ Other lung problems Specify: _____

Women:

- ❑ Take hormones or contraceptives
- ❑ Pregnant - expected due date: _____

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex
- ❑ Penicillin
- ❑ Codeine or other narcotics:_____
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Erythromycin
- ❑ Local Anesthetic
- ❑ Aspirin
- ❑ Other:_____

Have you ever taken any **bisphosphonates** such as Boniva, Fosamax, Actonel, Didronel, Skelid, Zometa, Aclasta, Aredia, Reclast, Evasta, Prolia, Atelvia?
If so, please list: _____

_____

Please list all of your **current medications:**

_____

_____

_____

Please list any **surgeries** with dates:

_____

_____

Physician Contact Information:

Name: _____

Phone Number: _____

Do you have any condition not listed above? _____

Patient/Guardian Signature: _____ Date: _____

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Smile Evaluation Form

Are you happy with the appearance of your teeth/gums/smile? ❑ Yes ❑ No

Would you like to discuss enhancing the appearance of your smile? ❑ Yes ❑ No

What don't you like about your smile? _____

Would you like to discuss how to make your teeth WHITE? ❑ Yes ❑ No