



Welcome to Fox Point Dental!

The information on this form will help us give you more reliable and successful treatment.
Please fill out both sides carefully and completely. Thank you.

Patient Name: _____ Residence Phone: _____
Email: _____
Residence Address: _____ City: _____ State: _____ Zip: _____
Occupation: _____ Birthdate: _____
Employer: _____ Business Phone: _____
Business Address: _____ City: _____ State: _____ Zip: _____
Social Security Number: _____
Marital Status: _____ Spouse Name: _____
Occupation _____

If someone other than the patient is responsible for payment, please fill out the following section.

Person Responsible For Payment: _____ Date of Birth: _____
Relation To Patient: _____
Occupation: _____ Social Security Number: _____
Employer: _____ Business Phone: _____
Business Address: _____ City: _____ State: _____ Zip: _____

If there is any form of dental coverage, please complete the following:

Name of Carrier: _____
Employer or Union: _____ Group Number: _____
Employee Name: _____
Employee Social Security Number: _____
Policy Holder's Date of Birth: _____
Has patient had care under this plan? _____ When? _____
Is patient covered under another plan? YES NO

Person not at your address to be contacted in case of an emergency.

Name: _____
Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

Treatment Authorization

I agree to diagnostic procedures and dental treatments as found necessary and desirable for the patient named above. This includes the use of study models, radiographs (x-rays), local anesthetic, and relaxing agents.
I agree to be financially responsible for treatment rendered.

Patient, Parent, or Legal Guardian

Date

Who may we thank for referring you to our office? _____

FOX POINT DENTAL - FINANCIAL AGREEMENT



DENTAL BENEFITS

If you have dental benefits, we are eager to help you receive your maximum allowable benefits. In order to achieve this goal we need your assistance and your understanding of our payment policy.

You will be asked to update your personal and dental benefit information periodically, including providing our office with copies of your benefit card. We are required by law to obtain your signature for permission to release information to your insurance carrier. We will gladly submit fees for your covered dental services to your insurance company. However, we expect payment of all services within 90 days. **It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 90 days.** It is your responsibility to understand your coverage and benefits, including pre-authorizations and authorization requirements. We will, however, assist you to ensure that all plan requirements are met.

Please initial _____

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date the services are rendered.

Please initial _____

PAYMENT FOR SERVICES

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance. We accept cash, checks, MasterCard, Visa and Discover.

Please initial _____

Returned checks will result in a \$35 fee that will be posted to your account. Returned checks, balances older than 90 days and failure to pay account balances as promised may be subject to external collection and additional collection fees, including attorney and other court fees.

Please initial _____

We will attempt to give you an estimate of your patient payment. This estimate may be altered by your dental plan, as it is subject to annual deductibles, maximums, waiting periods etc. However, regardless of an estimate that you may have received, any difference between the fee charged and the amount paid by the insurance company is your responsibility.

Please initial _____

GENERAL

We will gladly discuss your proposed treatment and answer any questions relating to your benefits. Your benefits are a contract between you, your employer and the insurance company. We are not a party to that contract. We must emphasize that as a dental care provider, our relationship is with you, not your insurance company.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

CANCELLED APPOINTMENTS

Charges may be incurred for broken, confirmed appointments and appointments canceled without 48 hours notice. Your cooperation in canceling your scheduled appointment well in advance allows us the opportunity to offer your appointment to a person who needs dental care. **Failure to show for (or cancel) a scheduled, confirmed appointment may result in a \$75 cancellation fee.**

Please initial _____

If you have any questions about the above information, please do not hesitate to ask us!

Thank you,
Fox Point Dental, Turner PLLC

My signature below constitutes acknowledgment and acceptance of this policy.

Patient name-Printed

Patient or guardian signature

Date

Health History



Patient Name: _____

Date: _____

Name of Physician or Clinic: _____

Last visit to your medical provider? _____

Do you have, or have you ever had, any of the following? Please check.

- | | | |
|---|--|--|
| <input type="checkbox"/> Abnormal Blood Pressure | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia or Blood Disorder | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tobacco Use |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tongue or Lip Tie |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> H.I.V. Positive | <input type="checkbox"/> Tonsil/Adenoid Removal |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Liver or Kidney Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> COVID-19 | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Tumor History |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Upper Airway Resistance |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Venereal Disease |

Do you have a medical problem? YES NO If yes, please explain: _____

Have you been hospitalized in the past five years? YES NO If yes, please explain: _____

Are you taking any prescribed medications? YES NO If yes, please list below:

Taking: _____

Are you taking any supplements or vitamins? YES NO If yes, please list below:

Taking: _____

Have you ever had a bad reaction or allergy to medication? YES NO If yes, please explain: _____

Have you had problems with: Codeine Penicillin Aspirin Local Anesthetic (Novocaine) Other

Do you take antibiotics before dental treatment? YES NO

Do you have any limitations in your activities? YES NO If yes, please explain: _____

Women: Are you pregnant? YES NO If yes, when is your delivery date? _____

Women: Are you nursing? YES NO

For Office Use Only-----

Medical History Reviewed: _____ Date: _____

Dental History



Patient Name: _____

Date: _____

How can we help you? What is your immediate dental concern? What are your treatment goals?

Date of Last Dental Visit: _____

Date of last full mouth x-rays: _____

Previous Dentist: _____

City: _____

State: _____

Are you presently having dental pain? YES NO If yes, where? _____

Have you noted any unusual changes in or around your mouth? YES NO If yes, where? _____

Have you lost any teeth? YES NO If yes, from what cause? _____

Have you had orthodontic treatment? YES NO If yes, how old were you? _____

Are you aware if you were breastfed as a baby? YES NO UNSURE

Are you pleased with the appearance of your teeth? YES NO

Do your gums bleed when brushing or flossing? YES NO

Do you avoid brushing or chewing in any part of your mouth? YES NO

Are any of your teeth sensitive to hot or cold, pressure, food or drink? YES NO If yes, explain: _____

Do you have any difficulty getting numb for dental procedures? YES NO

Have you been told you have pyorrhea or gum disease? YES NO

Have you ever had gum disease treatments? YES NO

Have you ever had gum graft treatments? YES NO

Do you ever experience burning mouth or tongue? YES NO

Do you have an unpleasant taste or odor in your mouth? YES NO

Have you noticed or have you been told that you snore? YES NO

Are you regularly unrefreshed, even after waking from a full night's sleep? YES NO

Do you use any type of appliance to sleep (mouthguard, CPAP, MAD, etc)? YES NO

Do you wake with morning headaches? YES NO

Are you aware of clenching or grinding your teeth, day or night? YES NO

Does your jaw pop or click when yawning or chewing? YES NO

Do you have any soreness in your neck, ears or face? YES NO

Is there anything we should know to give you better, more comfortable care? YES NO

If yes, please explain: _____

For Office Use Only-----

Dental History Reviewed: _____ Date: _____