THE Dentists ON RAYFORD

Confidential Medical Questionnaire

Welcome to The Dentists on Rayford! We're happy you're here. We know how much you dislike filling out paperwork, so we'll make this as quick and easy as possible…

Last Name _____ **First Name** _____ M ☐ F ☐

Contact	
CELL	
HOME	
EMAIL	

Address			
STREET			APT
CITY		STATE	ZIP

Info						
DATE OF BIRTH	MONTH	DAY	YEAR	OCCUPATION		
REASON FOR TODAY'S VISIT						
HOW DID YOU HEAR ABOUT US?						

Medical History

YES	NO	DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?
☐	☐	ANEMIA
☐	☐	ANXIETY DISORDERS
☐	☐	ARTHRITIS
☐	☐	ARTIFICIAL JOINTS (hip, knee, etc…)
☐	☐	ASTHMA
☐	☐	BLEEDING PROBLEMS (extended bleeding)
☐	☐	CANCER
☐	☐	DIABETES
☐	☐	DIGESTIVE PROBLEMS (ex: stomach ulcer, etc…)
☐	☐	DIZZINESS or FAINTING
☐	☐	EPILEPSY
☐	☐	FREQUENT HEADACHES
☐	☐	HEART PROBLEMS (ex: angina, heart attack, pacemaker, etc…)
☐	☐	HIGH BLOOD PRESSURE
☐	☐	IMMUNE DISORDERS
☐	☐	KIDNEY PROBLEMS
☐	☐	LIVER PROBLEMS (ex: cirrhosis, hepatitis, etc…)
☐	☐	OSTEOPOROSIS
☐	☐	SEXUALLY TRANSMITTED DISEASES (ex: herpes, HIV, etc…)
☐	☐	SKIN PROBLEMS
☐	☐	STROKE
☐	☐	THYROID PROBLEMS
☐	☐	TUBERCULOSIS or LUNG PROBLEMS
☐	☐	ARE YOU PREGNANT?
☐	☐	DO YOU SMOKE?

Text

CAN WE TEXT YOU APPOINTMENT REMINDERS?

YES ☐ NO ☐

Allergies

YES	NO	ARE YOU ALLERGIC?
☐	☐	ASPIRIN
☐	☐	CODEINE
☐	☐	LATEX
☐	☐	PENICILLIN
OTHER:		

Medications

LIST ALL MEDICATIONS YOU TAKE:

Other

ANY SIGNIFICANT HOSPITALIZATIONS OR SERIOUS ILLNESS?

YES ☐ NO ☐

DENTIST NOTES: ASA PS: I II III IV INITIAL BLOOD PRESSURE/PULSE:

I, the undersigned, hereby declare that I have read, understood, and answered the above medical questionnaire to the best of my knowledge. **I hereby promise to inform you of any change to my health.**

FOR THE DENTIST: I acknowledge that I have read the answers to the above questionnaire and discussed with the patient.

11/04/2020

Signature **Date** Dentist's Signature

THE Dentists ON RAYFORD

Financial and Personal Information

Responsible Party

WHO IS RESPONSIBLE FOR PAYING FOR YOUR DENTAL CARE? PLEASE LIST HIS/HER INFORMATION BELOW		
SOCIAL SECURITY NUMBER		
NAME (if not yourself)		

Insurance

TELL US ABOUT YOUR PRIMARY INSURANCE, IF ANY			
POLICY HOLDER NAME			
POLICY HOLDER EMPLOYER			
POLICY HOLDER DATE OF BIRTH	MONTH	DAY	YEAR

THIS PERSON IS MY:

☐ SELF ☐ SPOUSE/PARTNER ☐ MOTHER/FATHER ☐ OTHER _____

911

WHO SHOULD WE CALL IF THERE'S AN EMERGENCY?			
NAME		RELATIONSHIP TO YOU	
TELEPHONE			

Share Info

DO YOU WANT US TO DISCLOSE YOUR HEALTH INFORMATION TO SOMEONE ELSE?			
By law, we cannot discuss your information with anyone besides yourself and your legal guardian. If you'd like a parent, spouse, or someone else to be able to discuss your information, write his/her information below.			
NAME		RELATIONSHIP TO YOU	
NAME		RELATIONSHIP TO YOU	

HIPAA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A laminated copy of our privacy practices is behind this sheet and is on our website.
I have received a copy of this office's Notice of Privacy Practices. (You may refuse to sign this acknowledgement.)

_____ 11/04/2020

Signature Date

Financial Agreement

PLEASE READ THE FOLLOWING POLICIES, AND INITIAL TO INDICATE YOUR UNDERSTANDING AND AGREEMENT

I understand that my dental insurance policy is an agreement between me and my insurance company. For my convenience, I agree to allow The Dentists on Rayford to file claims on my behalf and authorize my insurance company to make payments directly to The Dentists on Rayford (Assignment of Benefits). _____ INITIALS

The Dentists on Rayford will be happy to help estimate my insurance benefits. However, I understand that my actual insurance coverage is often different than the estimated amount. I agree to pay, immediately upon notification, any balance that exists after my insurance company pays its share. _____ INITIALS

I agree to pay my account balance in full if The Dentists on Rayford is unable collect benefits from my insurance company. I understand that it's my responsibility to know the exact benefits of my plan and to manage my coverage. _____ INITIALS

I understand that annual deductibles and estimated co-payments, or full fees if I'm not insured, are due prior to my treatment. I can pay with cash or credit card; checks are not accepted. _____ INITIALS

I, the undersigned, hereby declare that I have read, understood, and agree to all office policies listed above. **I understand that I am responsible for all account charges regardless of my participation with dental insurance companies.**

_____ 11/04/2020 **You're done; thank you!**

Signature **Date**