Welcome *![C:\Documents and Settings\Owner\Local Settings\Temporary Internet Files\Content.IE5\49HCV6WN\MCj03319450000[1].wmf]()*

***We are pleased to welcome you to our practice!***

***Patient Information***

Patient’s last: First: \_\_\_\_\_\_\_\_\_ M.I.: \_\_Date:

Birth Date: Social Security # \_\_\_ \_\_\_ \_\_\_\_\_ Sex: \_ \_ Family Status: Single / Married / Divorced / Child / Other

Home Phone: Work: Cell: Other:

Physical Address: Apt # City: State: Zip:

Mailing Address (PO Box, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: State: Zip:

Email Address:

Preferred appointment times (please circle): Morning Afternoon Evening Anytime *![C:\Documents and Settings\Owner\Local Settings\Temporary Internet Files\Content.IE5\49HCV6WN\MCj03319450000[1].wmf]()* Days (please circle): Mon Tues Wed Thurs Fri Sat

How do you prefer to be contacted? Phone: Yes No / Email: Yes No / Text Messaging: Yes No

What Pharmacy do you prefer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: Name: Phone:

Whom may we thank for referring you to our practice?

![C:\Documents and Settings\Owner\Local Settings\Temporary Internet Files\Content.IE5\49HCV6WN\MCj03319450000[1].wmf]() Dental History ![C:\Documents and Settings\Owner\Local Settings\Temporary Internet Files\Content.IE5\49HCV6WN\MCj03319450000[1].wmf]()

Date of Last Dental Visit: Type of bristles on your brush: Hard Med Soft

Why have you come to the dentist today? Do you use anything in addition to your brush and floss? Y N If yes, what?

Are you currently in pain? Y N Do your gums bleed? Y N

Have you experienced problems associated with any previous Have you ever had periodontal disease?

 dental work? Y N Are your teeth sensitive to heat, cold, or anything else?

Do you now or have you ever experienced pain/

 discomfort in your jaw (TMJ/TMD)? Y N Have you lost any teeth? Y N If yes, why?

Your current dental health is: Good Fair Poor

Do you Brush Daily? Y N Floss Daily? Y N Do you still have your wisdom teeth? Y N

Are you happy with the way your smile looks? Y N Do you need to ***PRE-MED*** before dental work? Y N

If not, what would you change?

**Have you experienced the following dental problems?**



***Thank you for filling out this form completely. It will enable our office to be more effective in meeting your needs. If you have any questions at any time, please ask. We will be happy to help you.***

![C:\Documents and Settings\Owner\Local Settings\Temporary Internet Files\Content.IE5\49HCV6WN\MCj03319450000[1].wmf]() Medical History *![C:\Documents and Settings\Owner\Local Settings\Temporary Internet Files\Content.IE5\49HCV6WN\MCj03319450000[1].wmf]()*

Do you have a personal physician? Y N *For Women:* Are you pregnant? Unsure Y or N Week # \_\_\_\_\_\_\_\_\_

Physician’s Name Are you taking birth control? Y N Are you nursing? Y N

Address: Are you***ALLERGIC*** *to* any of the following?

City: State: Zip: Aspirin Codeine Jewelry Erythromycin

Phone #: Date of Last Visit? Barbiturates Sulfa Drugs Sedatives Penicillin

**Your current physical health is: Good Fair Poor** Tetracycline Dental Anesthetics Latex Other

Are you currently under the care of a physician? Y N Please list additional drugs that cause allergic reactions:

If yes, please explain:

Have you ever been hospitalized or had a serious illness or operation? Y N Do you smoke or use tobacco in any other forms? Y N

If yes, date and condition treated:

***Are you taking any of the following?***

Acetaminophen Blood Pressure Medication Nitroglycerin Antibiotics Cold Remedies Recreational Drugs

Antihistamines Digitalis/Heart Medication Steroids/Cortisone Aspirin or Ibuprofen Tranquilizers

Thyroid Medicine Insulin/Diabetes Drugs Blood Thinners Bisphosphonates Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any prescriptions or over the counter drugs? Y N If yes, please list each one:

**Have you experienced the following?**

Please List any serious medical condition(s) that you have experienced:

\*I understand the medical and dental history is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency. I will notify Dr. William L. Farrell DDS, of any change in my health or medication prior to treatment.

**Signature of Patient, Parent or Guardian Date**

**William L. Farrell DDS Assistant**

**I have verbally reviewed the Medical/Dental information above with the patient named herein.**  Initials\_\_\_\_\_\_\_\_\_\_\_\_\_ Date

**Doctor’s Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

![C:\Documents and Settings\Owner\Local Settings\Temporary Internet Files\Content.IE5\49HCV6WN\MCj03319450000[1].wmf]() Payment Information *![C:\Documents and Settings\Owner\Local Settings\Temporary Internet Files\Content.IE5\49HCV6WN\MCj03319450000[1].wmf]()*

***(FOR MINORS UNDER 18) Responsible Party Information***

Name: Relation to Patient

Social Security # Birth Date:

Home Phone: Work: Other:

Address:

City: State: Zip:

***Employment Information***

Employer Name: Occupation:

Address:

City: State: Zip: Phone:

***Dental Insurance Information***

***Primary Dental Insurance-***

Dental Insurance Company: ID#

Name of Policy Holder: Is Policy Holder a Patient? Y N

Social Security # Birth Date:

Dental Insurance Address: City: State: Zip:

***Secondary Dental Insurance-***

Dental Insurance Company: ID#

Name of Policy Holder: Is Policy Holder a Patient? Y N

Social Security # Birth Date:

Dental Insurance Address: City: State: Zip:

***Consent of Services***

I authorize Dr. William L. Farrell to take radiographs, study models, photographs and/or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of my dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication or therapy that may be indicated, authorize and consent that the Doctor choose and employ such assistance as he deems necessary. ***I also understand that, I the patient am responsibility for payment for Dental Services provided by this office for me and/or my dependents is solely mine;*** due and payable at the time of services are rendered. ***As a courtesy, our office will bill my insurance.*** Financial arrangements may be made in advance, including billing for dental insurance. However, I acknowledge that I am responsible for payment for all services rendered.

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

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

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he/she is personally responsible for payment. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient’s account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, 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 three months from the date of the patient examination.

In consideration for professional services, I agree to pay the full amount owed said services to William L. Farrell DDS, at the time services are rendered or within five (5) days of billing if credit shall be extended. 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 and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

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

***I have read the above conditions of treatment and agree to their content.***

**Signature of Patient, parent or guardian Date** Relationship to patient

![C:\Documents and Settings\Owner\Local Settings\Temporary Internet Files\Content.IE5\49HCV6WN\MCj03319450000[1].wmf]() Scheduling& Consent of Disclosure *![C:\Documents and Settings\Owner\Local Settings\Temporary Internet Files\Content.IE5\49HCV6WN\MCj03319450000[1].wmf]()*

***Scheduling your Next Appointment***

We make every effort to schedule appointments for the convenience of our patients. We need your cooperation to ensure that everyone has an opportunity for timely treatment. Please keep the following in mind:

***Early morning, late afternoon, appointments and Saturday (By appointment only) are in great demand in our office***. We will be happy to schedule you for one of these times if one is available, but we ask that you please make every effort to keep the appointment. Last minute changes often prevent us from offering these popular times to other patients who have requested them.

We fully understand that there are times when illness or unexpected obligations cause patients to reschedule appointments. However, we ask that you honor your appointments whenever possible so that you can stay on schedule and derive the maximum benefit from your treatment.

**Notice: We do not double/triple- book at this office and as a courtesy to other patients, we request that you notify us within 24 hours if you need to change your scheduled appointment*.***

***As of June 1, 2015: There will be a fee of $50.00 assessed if we do not receive a call to***

***cancel an appointment.***

***ALL Saturday Appointments: There will be a fee of $100.00 assessed if we do not receive a call to cancel an appointment. Failure to do so could result in termination of services.***

Thank you for choosing us for your dental care. If at any time, you have any questions about any of our services, please feel free to call us.

**(Signature) (Date)**

***Consent of Disclosure (****For the usage and/or Disclosure of Protected Health Information)*

I hereby give consent to William L. Farrell DDS, and all health care providers furnishing care within the offices of William L. Farrell DDS, to use and disclose my protected health information for the purposes of treatment, payment, and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address at the bottom of this form. This may be delivered by person or by mail, but it will only be effective when we physically receive it. Your cancellation will not be effective to the extent that we have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of you protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information about the usage and disclosure of your protected health information. You have the right to review our Posted Privacy Policy before you sign this consent.

We reserve the right to amend the terms of our Posted Privacy Policy. You may obtain a copy of the current policy by contacting the Office Manager.

**Patient Name (Please Print)**

**Signature of Patient Date / /**

If you are signing as the patient’s representative:

Relationship

*Address for cancelation: Your cancellation will be effective, upon receipt, at the following address:*

**William L. Farrell D.D.S., 9461 Deschutes Road, Suite 2 Palo Cedro, CA 96073**