# FORREST & FORREST FAMILY DENTISTRY

## M. BRAD FORREST & STACY OLLER FORREST, DMD, PA

WELCOME! THANK YOU FOR CHOOSING US AS YOUR DENTAL PROVIDER. OUR PRIMARY CONCERN IS THAT YOU RECEIVE THE BEST TREATMENT POSSIBLE TO MAINTAIN AND RESTORE YOUR OPTIMAL DENTAL HEALTH. PLEASE TAKE SOME TIME TO FILL OUT THE INFORMATION INCLUDED IN THIS PACKET. THIS IMPORTANT INFORMATION WILL HELP US SERVE YOU BETTER THROUGHOUT THE COURSE OF YOUR DENTAL CARE. IF YOU HAVE ANY QUESTIONS WE'LL BE GLAD TO HELP YOU. WE LOOK FORWARD TO WORKING WITH YOU IN MAINTAINING YOUR DENTAL HEALTH.

**PATIENT INFORMATION (Confidential)*:*** **Date:** _____/_____/_____

First Name _____Middle Initial _____Last_____

Preferred Name_____ Birth Date_____/_____/_____ SS# _____-_____-_____

Home Phone #_____ Work Phone#_____

Cell Phone # _____

Address_____ City _____ State _____ Zip _____

Employer_____ Business Address_____

City_____ State_____ Zip Code_____ E-mail Address_____

Where do you prefer to receive calls? □ Home □ Work □ Either

Spouse's Name_____ Employer _____Wrk#_____

Emergency Contact_____ Relationship _____ Phone#_____

How did you hear about our practice? _____

**PRIMARY DENTAL INSURANCE (**Must be fill out completely in order to file your claim)

NOTE: **You** are responsible for any procedure **not covered** or **not paid** by your insurance.

Insurance Name_____Phone#_____

Insurance Address_____

Employee Name_____

SSN# of Employee_____-_____-_____ Employee's DOB_____-_____-_____

Group#_____ Business/Employer Name _____

NOTE: **SUBSCRIBER ID#** (If Different from the SSN#):_____ Payor ID#:_____

**PARENTAL INFORMATION** (Please fill out completely if patient is a *minor*)

Father_____ Father's Address_____

Home Phone #_____ Work# _____ Cell# _____

Birth Date_____/_____/_____ SS #_____-_____-_____

Employer _____

Mother _____Mother's Address (If different)_____

Home Phone #_____ Work# _____ Cell# _____

Birth Date_____/_____/_____ SS #_____-_____-_____

Employer _____

Who is financially responsible for this account? _____

**DENTAL HISTORY**

What would you like us to do today?_____

Are you in dental discomfort today?_____

Would you be interested in whitening your teeth?_____

If there is one thing that you would like to change about your smile, what would it be?

_____

Former Dentist_____Phone_____

Date of Last Dental Care _____Date of last X-rays_____

**Check (√) if you have had problems with any of the following:**

| | | |
|---|---|---|
| ☐ Bad Breath | ☐ Food collection between teeth | ☐ Sensitivity to hot |
| ☐ Bleeding Gums | ☐ Grinding or clenching teeth | ☐ Sensitivity to cold |
| ☐ Clicking or popping jaw | ☐ Loose teeth or broken fillings | ☐ Sensitivity to sweets |
| ☐ Periodontal Treatment | ☐ Sensitivity when biting | ☐ Mouth Sores/Growths |

How often do you brush?_____Floss?_____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?

☐YES ☐NO If yes, explain_____

Other information about your dental health or previous treatment_____

## MEDICAL HISTORY

Physicians Name_____Phone#_____

Date of last visit_____ Have you ever had any serious illness or operations? ☐YES ☐NO

If yes, please describe_____

Are you currently under physician care? ☐YES ☐NO If yes, please describe _____

Have you ever had a blood transfusion? ☐YES ☐NO If yes, give approximate dates_____

Women: Are you pregnant? ☐YES ☐NO Nursing? ☐YES ☐NO Taking Birth Control Pills ☐YES ☐NO

**Check (√) if you have had any of the following:**

| | | | |
|---|---|---|---|
| ☐ AIDS/HIV Positive | ☐ Anaphylaxis | ☐ Anemia | ☐ Arthritis, Rheumatism |
| ☐ Artificial Heart Valves | ☐ Artificial Joints | ☐ Asthma | ☐ Allergy Prone |
| ☐ Back Problems | ☐ Blood Disease | ☐ Cancer | ☐ Chemical Dependency |
| ☐ Chemotherapy | ☐ Circulatory Problems | ☐ Cortisone Treatment | ☐ Cough (persistent) |
| ☐ Cough-up blood | ☐ Diabetes | ☐ Epilepsy | ☐ Fainting |
| ☐ Food Allergies | ☐ Glaucoma | ☐ Headaches | ☐ Heart Murmur |
| ☐ Heart Problems *describe* | ☐ Hemophilia/abnormal bleeding | ☐ Herpes | ☐ Hepatitis |
| | ☐ Kidney Disease **or** Malfunction | ☐ Liver Disease | ☐ Material Allergies i.e. latex, wool, metals, chemicals - *describe* |
| ☐ Pacemaker/Heart Surgery | ☐ High Blood Pressure | ☐ Jaw Pain | |
| ☐ Mitral Valve Prolapse | ☐ Nervous Problems | ☐ Psychiatric Care | ☐ Rheumatic/Scarlet Fever |
| ☐ Rapid Weight Loss/Gai | ☐ Radiation Treatment | ☐ Respiratory Disease | ☐ Shortness of Breath |
| ☐ Skin Rash | ☐ Spina Bifida | ☐ Stroke | ☐ Tonsillitis |
| ☐ Shingles | ☐ Swelling of Feet or Ank | ☐ Thyroid Disease **or** Malfunction | ☐ Tobacco Habit |
| ☐ Surgical Implants | ☐ Ulcer/Colitis | ☐ Venereal Disease | |

**List medications you are currently taking if any**_____

**List drug allergies if any**:_____

## AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature:_____Date:_____

# Forrest & Forrest Family Dentistry
# At Stevens Mill Crossing

## Consent for Service

Your dental care is our primary concern. As a condition for your treatment by this office, financial arrangements for payment of services must be made in advance of your appointment by the patient.

I understand that insurance is a contract between the insurance company and the patient. Patients who carry dental insurance understand he or she is financially responsible for all treatment provided including any procedure not covered or paid by insurance. It is the patient's responsibility to be aware of their own insurance benefits. This office will gladly file your insurance for you as a courtesy and will accept assignment of benefits (payments) to come to our office, with the exception of Delta Dental, however, we do not guarantee any estimate of benefits or payment from the insurance company. We use the latest technology in filing claims to assure maximizing your insurance benefit.

I understand that any fee estimate given by this office for any dental care can only be guaranteed for a period of ninety (90) days from the date of the patient examination.

We understand there may be situations when canceling your appointment is necessary. However, in the event that 2 (TWO) BUISNESS DAYS notice is not given, a charge of 25% OF THE SCHEDULDED APPOINTMENT FEE will be applied to you account.

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

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

_____**Date**_____

**Relationship to Patient**_____
Signature of Guarantor of payment/Responsible Party

## Payment for Your Dental Care

Your insurance is a contract between you and your insurance company. We gladly file your insurance for you as a courtesy and will accept assignment of benefits (payments) to come to our office, with the exception of Delta Dental. Financial arrangements for payment of services must be made in advance of your appointment.

**You are financially responsible for all treatment provided including any procedure not covered or paid by your insurance**.

We accept cash, as well as, MasterCard, VISA, Discover, and American Express cards.
We offer a 5% senior citizens discount for patients who are at least 65 years of age.
We also offer financing plans through outside companies with no-interest and low-interest plans to qualified participants.

Please call if you have any questions. We will be glad assist you in any way we can.

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

_____**Date**_____

**Relationship to Patient**_____
Signature of Guarantor of payment/Responsible Party