DR. PAT FREEMAN, D.D.S., P.C.

Accredited Member American Academy of Cosmetic Dentistry
Member American Dental Association
Member Academy of General Dentistry

PATIENT INFORMATION (COMPLETE IN BLACK INK)

NAME _____ (LAST) _____ (FIRST) _____ (MI) _____ (SPOUSE'S NAME)

MAILING ADDRESS _____ (MAILING ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

_____ (SOC. SEC. NUMBER) ( ) _____ (AC) _____ (HOME PHONE) ( ) _____ (AC) _____ (BUSINESS PHONE) _____ (EXT)

M F (SEX) _____ (DATE OF BIRTH) _____ (YOUR OCCUPATION) _____ (EMPLOYER)

DRIVER'S LICENSE # _____ (ISSUING STATE) _____ (CELL PHONE) _____ (EMAIL ADDRESS)

RESPONSIBLE PARTY INFORMATION

IF DIFFERENT FROM ABOVE

_____ (RESPONSIBLE PARTY OCCUPATION) _____ (EMPLOYER)

NAME _____ (LAST) _____ (FIRST) _____ (MI) _____ (RELATIONSHIP TO PATIENT)

ADDRESS _____ (NUMBER & STREET) _____ (CITY) _____ (STATE) _____ (ZIP) ( ) _____ (AC) (HOME PHONE)

( ) _____ (AC) (BUSINESS PHONE) _____ (EXT) _____ (SOC. SEC. NUMBER) _____ (SEX) _____ (DATE OF BIRTH)

_____ (SPOUSE'S OCCUPATION) _____ (EMPLOYER)

SPOUSE _____ (FIRST NAME) _____ (MI) _____ (DATE OF BIRTH) _____ (SOC. SEC. NUMBER) ( ) _____ (AC) (BUSINESS PHONE) _____ (EXT)

DENTAL INSURANCE INFORMATION (We need to make a copy of your card. Please present it to the receptionist.)

DENTAL INSURANCE PRIMARY CARRIER

INSURED'S NAME _____

INSURANCE CO. _____

INSURANCE CO. ADDRESS _____

_____

INSURED'S EMPLOYER _____

INSURED'S SOC. SEC. # _____

INSURED'S BIRTHDATE _____

GROUP # _____ ID# _____

DENTAL INSURANCE SECONDARY CARRIER

INSURED'S NAME _____

INSURANCE CO. _____

INSURANCE CO. ADDRESS _____

_____

INSURED'S EMPLOYER _____

INSURED'S SOC. SEC. # _____

INSURED'S BIRTHDATE _____

GROUP # _____ ID# _____

IF YOU ARE COMPLETING THIS FORM FOR ANOTHER PERSON, WHAT IS YOUR RELATIONSHIP TO THAT PERSON? _____

IN CASE OF EMERGENCY,
CLOSEST RELATIVE OR FRIEND NOT LIVING WITH YOU: _____ (NAME) _____ (DAYTIME PHONE) _____ (EVENING PHONE)

REFERRALS ARE IMPORTANT TO US, PLEASE TELL US HOW YOU FOUND OUR OFFICE.

NAME _____ ☐ OTHER _____

ASSIGNMENT AND RELEASE:
I hereby authorize my insurance benefits be paid directly to Patrick O. Freeman, D.D.S., P.C. and I am financially responsible for non-covered services. I also authorize Patrick O. Freeman, D.D.S., P.C. to release any information required, related to insurance claims.

SIGNATURE _____ DATE _____

MEDICAL HISTORY

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N)

LIST MEDICATIONS AND COMMENTS

Has there been any change in your general health in the past year? ..... Y / N
If so please describe .....
Are you under a physicians care for a particular problem? Physician's Name? Telephone? ... Y / N
If so please describe .....
Have you had a serious illness, operations or hospitalizations? ..... Y / N
If so please describe .....
Have you had any adverse effects from dental treatment? ..... Y / N
If so please describe .....

Do you have or have you ever had?

Infective Endocartitis (serious heart infection requiring hospitalization)? ..... Y / N
Were you born with any heart defects? ..... Y / N
Do you have an artificial heart valve? ..... Y / N
Have you had any stents placed in your heart in the last six months? ..... Y / N
If so when? .....
Cardiovascular disease, heart trouble, heart attack, heart murmur, angina coronary artery disease, high blood pressure, stroke, TIA, palpitations, heart surgery, pacemaker? ..... Y / N
Lung disease, asthma, emphysema, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing? ..... Y / N
Seizures, convulsions, epilepsy, fainting, psychiatric treatment, dizziness, nervous disorder, breakdown? ..... Y / N
Bleeding disorder, anemia, bleeding tendency, blood transfusion, tendency to bruise? ..... Y / N
Acid reflux or GERD (Gastroesophageal reflux disease)? ..... Y / N
Liver disease, jaundice, hepatitis? ..... Y / N
Kidney Disease? ..... Y / N
Diabetes? ..... Y / N
If so, are you insulin dependent, take oral medication or diet controlled? .....
Thyroid disease, goiter, hypothyroid, hyperthyroid? ..... Y / N
Arthritis? ..... Y / N
Stomach ulcers? ..... Y / N
Glaucoma? ..... Y / N
Frequent or recurring mouth sores? ..... Y / N
Artificial joints placed anywhere in your body: hip, knee, shoulder? ..... Y / N
If so when? .....
Radiation or chemo treatment for Cancer? ..... Y / N
Do you take medication for osteoporosis such as Aredia, Zometa, Boniva, or Fosamax? ..... Y / N
Sleep Apnea? ..... Y / N
Do you use a CPAP machine? ..... Y / N
Sinus or nasal problems? ..... Y / N
Has any condition suppressed your immune system/HIV? ..... Y / N
Recurring infections of any kind? ..... Y / N
Sexually transmitted diseases? ..... Y / N
Alcohol or drug addiction? ..... Y / N
Do you smoke or chew tobacco? ..... Y / N

MEDICAL HISTORY

LIST MEDICATIONS AND COMMENTS

Are you taking any of the following?

Tagament? ..... Y / N
Thyroid medication? ..... Y / N
Anticoagulants (blood thinners) such as Coumadin or Warfarin? ..... Y / N
High Blood pressure medicine? ..... Y / N
Steroids (Cortisone, etc)? ..... Y / N
Sedatives (Valium)? ..... Y / N
Insulin Glyburide, Glucophage, or similar drug? ..... Y / N
Antibiotics or sulfa drugs? ..... Y / N
Digitalis, Inderal, Nitroglycerin, calcium channel blockers, Procardia,
or other heart medicine? ..... Y / N
Aspirin, Acetaminophen (Tyienol) or Ibuprofen (Advil)? ..... Y / N
Marijuana or other "street drugs?" ..... Y / N
Antihistamines or decongestants? ..... Y / N
Do you take any homeopathic or herbal products on a regular basis? ..... Y / N
Are taking any other doctor prescribed medication, pill or drug? ..... Y / N
If so please list: .....
.....
Do you have any other disease, condition or problem not listed that you think
the doctor should know about? ..... Y / N

Are you allergic to or had a bad reaction to:

Local anesthesia (Novocaine, Xylocaine, Epinephridine, ect)? ..... Y / N
Penicillin, Amoxicillin, Sulfa, Cephalosporins? ..... Y / N
Barbiturates, sedatives? ..... Y / N
Aspirin, Acetaminophen, or Ibuprofen? ..... Y / N
Codeine or other pain killers? ..... Y / N
Latex or rubber products? ..... Y / N
Food, sulfites? ..... Y / N
Other allergies or reactions? ..... Y / N

Clicking or popping of jaw joint, pain near ear, difficulty opening mouth? ..... Y / N
Do you grind or clench your teeth? ..... Y / N
When was your last visit to a dentist? _____
When was your last dental hygiene visit? _____

I understand the importance of a truthful health history to assist the Doctor on providing the best care possible.

Patient (parent/guardian) signature: _____ Date _____

For Women only

If you are using oral contraceptives, it is important that you understand that antibiotics and other medication may interfere with the effectiveness of oral contraceptives. Therefore you will need to use mechanical forms of birth control for one complete cycle of birth control pills after the course of the antibiotics or other medication is completed. Please consult your physician for further guidance. If you are pregnant (possibly pregnant or trying to become pregnant) surgery, anesthesia, or any other medication may significantly harm your developing baby, especially during the first trimester.

Are you pregnant or is there any possibility of being pregnant? ..... Y / N

FINANCIAL POLICY AND AGREEMENT
Patrick O Freeman, D.D.S., P.C.

Thank you for choosing Pat Freeman Dental as your dental care provider. Our staff is committed to providing you with the highest quality dental care using the highest quality materials and state of the art technology available. We are committed to building a successful relationship with you and your family and your understanding of payment for services is important for both of us. Patients are responsible to keep us up to date with any changes in personal contact and insurance information.

Full payment for dental treatment is required on the date of service. A 5% bookkeeping courtesy is offered for payments made in with cash or personal check only. Credit/Debit cards and approved Care Credit lines of credit are also accepted but no discount can be given.

DENTAL INSURANCE

Insurance is a contract between you and your insurance company/employer. It is your responsibility to understand the coverage and exceptions of your particular policy. Patients with dental insurance are fully responsible for all fees charged by this office that are not covered by your dental insurance plan. We will always do our best to help you maximize your benefits but understand that Dr. Freeman will diagnose treatment based on your individual dental health needs and not your insurance coverage. Your estimated co-pay is due on the day of service. As a courtesy to you, we will promptly file your insurance claim. Upon our receipt of your dental benefits our office will mail a final billing statement to you which is payable upon receipt**.** For some out of network insurance's it may become necessary for us to collect payment in full on the day of service. **It is the patient's responsibility to provide us with accurate insurance information at each visit.**

FORMS OF PAYMENT ACCEPTED

Our office accepts Cash or Check, Visa, MasterCard, and Discover credit cards, Debit and HSA cards. We also accept personal approved lines of CareCredit at the 6 month interest free option. See the front desk for information about Care Credit.

MISSED APPOINTMENTS

Our office requires a minimum 24-hour notice for missed appointments. This allows our office to offer the appointment time to another patient on a waiting list. Cancellations without proper notice can lead to a late cancellation fee up to $50 applied to your account. We understand that plans can change but please help us to serve you and other patients better by keeping your scheduled appointments.

PAST DUE BALANCES

Account balances over 60 days will be charged interest at a rate of 1.5% per month in addition to a $5.00 monthly billing fee. Outstanding balances after 90 days, plus any assessed finance charges, may be sent to an outside collection agency.

REFUNDS

If for any reason your account balance becomes a credit, a refund check is immediately processed and sent to the guarantor of the account. Our office can hold credit balances for future treatment only at the request of the patient.

Please do not hesitate to ask at the front desk if you have any questions regarding our financial policy/agreement. Our staff is happy to assist you if you should have any questions regarding your account.

Patient signature _____ Date_____

Revised (06/2014)