Commonwealth Dentistry Medical History

Patient Name	Social Security Number
Gender	Date of Birth

Address _____ Primary Phone _____

City _____ State _____ Zip _____ Email _____

Referred By _____ Emergency Contact's Name _____ Primary Phone _____

Parent or Guardian (if under 18) _____ Primary Phone _____

Address _____ Date of Birth _____

Employer _____ SSN _____

Spouse _____ Primary Phone _____

Address _____ Date of Birth _____

Employer _____ SSN _____

Please answer the each of the following:

1. Date of your last physical examination: _____ Physician's Name: _____
2. Have you been hospitalized during the past two years? ☐ No ☐ Yes, _____
3. Have you been under the care of a physician in the past two years? ☐ No ☐ Yes, _____
4. Are you allergic to (i.e., itching, rash, swelling of hands, feet, or eyes) or made sick by penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? ☐ No ☐ Yes, _____
5. Have you ever had excessive bleeding requiring special treatment? ☐ No ☐ Yes, _____
6. Check any of the following you **have had** or **have at present**:

☐ Heart Failure	☐ Heart Disease/Attack	☐ Angina Pectoris	☐ High Blood Pressure
☐ *Mitral Valve Prolapse	☐ *Heart Murmur	☐ *Rheumatic Fever	☐ *Congenital Heart Lesions
☐ Heart Pace Maker	☐ Heart Surgery	☐ Anemia	☐ Cancer, _____
☐ Stroke	☐ Epilepsy Or Seizures	☐ Psychiatric Treatment	☐ *Artificial Hip, Knee, Or Other Joint
☐ Kidney Disorders	☐ Ulcers	☐ Diabetes	☐ Emphysema
☐ Tuberculosis (TB)	☐ Asthma	☐ Sinus Problems	☐ Hay Fever
☐ Bruise Easily	☐ Allergies or Hives	☐ Radiation Treatment	☐ Chemotherapy
☐ Jaundice	☐ Arthritis	☐ Fainting Or Dizzy Spells	☐ Sickle Cell Disease
☐ Thyroid Condition	☐ Glaucoma	☐ HIV Positive, ARC, AIDS	☐ Alcoholism
☐ Drug Addition	☐ Cold Sores	☐ Cortisone Medicine	☐ Hepatitis, _____
☐ Liver Disease	☐ *Any Type Of Implant	☐ Blood Transfusion	☐ Bleeding Disorder
☐ Herpes	☐ *Any Type Of Transplant	☐ Use Of Tobacco Products	☐ Spina Bifida
☐ Autism	☐ Down Syndrome	☐ Developmental Delays	☐ ADHD

*** Antibiotic pre-medication may be required prior to your appointment**

7. Please list all medications that you are currently taking (including over the counter medications, vitamins, or herbal remedies _____

_____

8. **Women**: Are you pregnant? ☐ No ☐ Yes Are you nursing? ☐ No ☐ Yes Are you taking birth control pills? ☐ No ☐ Yes

9. Have you been out of the country in the past six (6) months? ☐ No ☐ Yes, _____

10. Have you had any contact with anyone who has been out of the country in the last six (6) months? ☐ No ☐ Yes

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Dental Insurance ☐ No ☐ Yes

Name of Insurance Company _____ Phone _____

Subscriber's Name _____ SSN _____ Date of Birth _____

Secondary Insurance Company _____ Phone _____

Subscriber's Name _____ SSN _____ Date of Birth _____

BELTRAMI, DIXON, WOODARD, AND ASSOCIATES FAMILY FINANCIAL POLICY REQUIRES PAYMENT AT TIME SERVICES ARE RENDERED.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. Should my treatment be extensive, I may request additional information regarding financial plans. In the event that any balance on my account must be placed for collection, I agree to pay the collection agency fees up to 32%, reasonable attorney's fees, and all court costs. I understand that all amounts over 30 days after treatment are subject to finance charge of 1.5% per month (18% annual rate) I am aware that should I fail to keep an appointment without giving 24 hour notice, I will be charged a broken appointment fee.

_____

Patient (Or Guardian's) Signature Today's Date

Commonwealth Dentistry

Mark Beltrami, DDS
Bryan Dixon, DDS
McKenzie Woodard, DDS
Phyllis Greer, DDS
Amanda Hoover, DDS
Afia Rasul, DDS
Luiza Kreuzer, DDS
Clint Meadows, DDS

Welcome to our practice! We would like to thank you for choosing us to meet all your dental needs. We have a friendly staff who are here to help you in any way we can. We do many facets of dentistry up to and including Bonding, Veneers, Fillings, Crowns, Bridges, Dentures, Partials, and Whitening. We also offer conscious sedation for those patients who are anxious and we offer LASER dentistry. Below is a list of our office policies. Please read and sign at the bottom. If you have any questions or do not understand please do not hesitate to ask.

WE WILL file insurance claims for most any insurance, We also estimate what the patient's co-payment will be which is due at the time of your dental visit. We do call and get an estimate of benefits from each insurance company, however, it is up to the patient to pay whatever the insurance does not cover.

Initial _____

There is a broken appointment fee of $20.00 per 15 minutes for any appointment that is not canceled within 24 hours. We do understand when an emergency arises.

Initial _____

We take cash, checks, MasterCard, VISA, Discover, American Express, and Care Credit. We also offer several different financial plans.

Initial _____

How would you like to be notified for appointments?

☐ Email _____

☐ Phone _____

Thank you again for choosing **Commonwealth Dentistry** to meet all your dental needs.

_____

Patient (Or Guardian's) Signature

Today's Date

Commonwealth Dentistry

Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing, that you restrict how my private information is used and disclosed to carry out treatment, payment, or health care operations. I also understand you are required to agree to my requested restrictions and if you agree then you are bound to abide by such restrictions.

Patient's Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

I have explained to the patient, _____ , that disclosure may be made to family and friends related to patient's health or as needed for payment of dental services. I have explained that we will only disclose information that is relevant to current treatment. Our patient has agreed that we may disclose health care information in person or by telephone to:

_____ Relationship: _____

_____ Relationship: _____

_____

Patient (Or Guardian's) Signature Today's Date