Welcome to

FARREY FAMILY DENTISTRY, LLC

Patient Information

Patient :_____

Last *First* *Preferred Name*

Date of Birth: _____Social Security Number: _____

Address: _____

Street *City* *State* *Zip*

Home Phone: _____ Cell: _____ Work: _____

(Please list all contact numbers, there may be times when we need to get a hold of you on short notice.)

Email Address: _____ Employer: _____

Spouse's Name:_____ DOB: _____ SSN:_____

Spouse's Employer: _____ Spouse's Work Number:_____

Emergency Contact Information:

Name of your emergency contact: _____ Phone Number: _____

Referral Information:

Whom or what may we thank for referring you to our office:

Responsible Party

Self: _____ Other: _____

Last *First* *Middle*

If "Other" please complete:

Address: _____

Street *City* *State* *Zip*

Home Phone: _____ Cell: _____ Work: _____

If you have Dental Coverage, please fill out:

Subscriber Name: _____DOB: _____ SSN: _____

Insurance Name _____ Employer:_____

Group #: _____ Insurance Phone Number_____

FINANCIAL DISCLOSURE POLICY

At Farrey Family Dentistry, LLC (FFD) it is our mission to provide the best possible dental care for our patients. In an effort to keep our fees affordable, payments are due at the time of service. We accept cash, check, debit, Visa and Master Card. For patients with dental insurance, we will gladly accept assignment of your insurance benefits to FFD if you provide us with accurate information. We make every effort to closely estimate your insurance coverage for treatment. Please understand this is only an "estimate". Should the need for additional treatment arises during the original treatment plan, the fees could change. However, there are times when insurance under pays or denies payment on a claim for a variety of reasons. Any remaining balance not paid by insurance within 60 days will become the responsibility of the patient or the patient's guardian if the patient is a minor. I accept full responsibility for this account and for all dentistry performed upon myself and my dependents in this dental office. I understand that this office cannot guarantee my insurance eligibility, waiting periods and/or benefits. I have read and understand my obligations and I acknowledge that I am fully responsible for payment of any service not covered or underpaid by my insurance carrier. I am aware that my account may be sent to a third party collection agency if I don't pay on my account and that additional fees may apply from the third party collection agency. NO REFUNDS ALLOWED. Your signature below indicates that you have read, understand and agree to this policy.

Patient's Signature: _____ Date: _____

(Or Guardian if patient is a minor)

Patient Medical History

Have there been any changes in your general health within the past year? YES NO

If so, what conditions are being treated? _____

Physician's Name: _____ **Phone #**:_____

Have you ever been hospitalized or had a serious operation or illness? YES NO

If so, what condition was treated and when? _____

Do you have or have you had any of the following diseases or problems? Please check

___*Drug Use/Abuse*	___*Heart Disease*	___ *High Blood Pressure*
___*Heart Attack*	___*Cardiac pacemaker*	___*Easily Winded*
___*Rheumatic fever*	___*Heart Murmur*	___*Stroke*
___*Swollen ankles*	___*Angina*	___*Hay fever/Allergies*
___*Fainting/Seizures*	___*Frequently Tired*	___*Tuberculosis (TB)*
___*Asthma*	___*Anemia*	___*Radiation Therapy*
___*Chemotherapy*	___*Emphysema*	___ *Chest pains*
___*Epilepsy*	___*Cancer*	___*Recent Weight Loss*
___*Arthritis*	___*Liver Disease*	___*Diabetes*
___*Joint Replacement*	___*Implant*	___*Heart trouble*
___*Kidney Disease*	___*Hepatitis A/B/C*	___*Respiratory Problems*
___*AIDS or HIV*	___*STD*	___*Mitral valve Prolapse*
___*Thyroid Problems*	___*Stomach trouble/Ulcers*	___*Other*_____

Are you taking any drugs, medicine or herbal supplements? YES NO

If so, what _____

ALLERGIES: Are you allergic or have you reacted adversely to any of the following:

___*Local Anesthetics (Novocain/Lidocaine)*	___*Sulfa Drugs*	___*Metal*
___*Aspirin*	___*Latex*	___*Iodine*
___*Barbiturates*	___*Sedatives*	___ *Other* _____
___*Ibuprophen*	___*Cherry/Strawberry/Cinnamon*	

FOR WOMEN ONLY:

Are you pregnant or breast feeding? YES NO Are you taking Birth control ? YES NO

Doctor Notes

_____

_____

_____

Health HX Review

Date_____

Date_____

Date_____

Date_____

Date_____

Date_____

Date_____

Date_____

Date_____

Date_____

Date_____

Patient Dental History

What's your chief complaint _____

Do your gums bleed while you brush or floss? YES NO

Are your teeth sensitive to hot or cold liquids or foods? YES NO

Are you teeth sensitive to sweet or sour liquids or foods? YES NO

Do you feel any pain in your teeth? YES NO

Do you have any lumps or sores in your mouth? YES NO

Do you bite your lips or cheeks frequency? YES NO

Have you had orthodontic treatment before? YES NO

Have you had any serious trouble from treatment? YES NO

Do you require antibiotic prophylaxis/premedication? YES NO

List Current Medications

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Are you taking **blood thinners** or **bone medication**?

Yes No If so, list:

TMJ HISTORY

Please circle if you ever experienced any of the following problems listed below concerning your jaw joint:

Clicking, pain (joint, ear, side of face), difficulty opening or closing, difficulty chewing, popping or locking of jaw

Explain_____

Do you have frequent headaches? YES NO

Do you clench or grind your teeth? YES NO

Do you have problems opening your mouth wide? YES NO

GENERAL CONSENT TO TREATMENT, RELEASE OF RECORDS, & PHOTOGRAPHY

The undersigned hereby authorized the dentist of Farrey Family Dentistry Dentistry, LLC (FFD) to take radiographs, photographs or any other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis of the patient's dental needs. I also understand the use of anesthetic agents embodies a certain risk. I authorize FFD to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers/advisors and/or healthcare practitioners. I acknowledge I have had the opportunity to read FFD Notice of Privacy Practices and a copy was available to me. I give authorization FFD to utilize any photographs taken for educational/ promotional purposes. Your signature below indicates that you have read, understand and agree to these consents.

Patient's Signature: _____ Date: _____

(Or Guardian if patient is a minor)

I have revised this application on _____OFFICE USE ONLY Signature_____