



ALAN J FOSTER, DDS

PATIENT HISTORY & INFORMATION

Today's Date
Patient's Name
Home Address
Social Security #
Cell Phone #:
Email Address:
Gender (circle): Male Female
Relationship Status (circle): Married Single Divorced Widowed Partnered Minor
Employer
Occupation
Work Phone:
Emergency Contact (not spouse):
Relationship:
Phone:
Spouse's Name:
Address
Birth date
Social Security #
Home #:
Spouse's Employer/Occupation
Work#:

PERSON RESPONSIBLE FOR ACCOUNT

Name
Relationship to patient
Home #:
Address
Birth date
Social Security #:
Employer name:
Work#:

CONFIDENTIAL HEALTH HISTORY

Family Physician
Address
Phone#:
Are you currently under the care of a physician?
Are you taking any medications at this time?
If yes, please list:
Have you ever experienced any reaction to any of the following drugs?
Please list any other allergies:
Have you had any heart valve replacements?
Have you had any joint replacements?
(Women) Are you pregnant?
Do you or have you ever had any of the following?

- High/Low blood pressure
HIV/AIDS
Tuberculosis
Blood Transfusion
Heart Murmur
Low Blood Sugar
Emphysema
Diabetes
Epilepsy
Heart disease
Blood Thinners
Alcohol/Drug addiction
Herpes
Stroke
Heart palpitation
Cancer
Hepatitis
Venereal disease
Asthma
Mitral Valve Prolapse
Radiation/Chemo
Rheumatic fever
Crohn's disease
Pacemaker
Tobacco use

Continued on following page:

**DENTAL HISTORY:**

What is your chief reason for visiting us today? \_\_\_\_\_

Have you ever experienced any reaction to any dental anesthetic.....Yes No

Have you ever had any of the following dental procedures/conditions: (Check all that apply)

Orthodontics/Braces, if yes, when: \_\_\_\_\_  Partial or full dentures  Root Canal  Crown/Bridge  Implant

Diagnosed with gingivitis/gum disease

Are you satisfied with the appearance of your smile?  Yes  No

If no, please tell us what you would like to see differently or change about your smile: \_\_\_\_\_

Are any of your teeth sensitive to hot, cold or pressure?  Yes  No If yes, please describe: \_\_\_\_\_

Name of your previous dentist: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Date of your last dental exam: \_\_\_\_\_ Date of last x-rays: \_\_\_\_\_

Is there anything else that we should know about your health ? \_\_\_\_\_

Who can we thank for referring you to our practice? \_\_\_\_\_

**FINANCIAL POLICY/PAYMENT INFORMATION**

- 1. I have no dental insurance.
- 2. I have dental insurance.
- 3. I am interested in extended payment plan arrangements.

**AUTHORIZATION:**

I grant authority to the Dentist to perform procedures and treatments including administration of medicine, local anesthetics, and extractions, along with other surgical and dental procedures that may be necessary.

All account balances over 60 days will accrue a 1.5% per month late fee. I/We agree to pay collection costs and/or a reasonable attorney's fee if any delinquent balance is placed with an agency or attorney for collection or suit.

I authorize the Dentist to contact a credit reporting service, if necessary, for collection.

**DENTAL BENEFITS EXPLANATION**

It is our policy to provide the best dentistry for you. To do this, it is important that we do not allow dental insurance to be a determining factor in the diagnosis. Your treatment will be based upon your needs, and we assume that you are as concerned as we are about maintaining your good health.

The term "Dental Insurance" can be misleading. What is commonly known as "Dental Insurance" is more correctly termed Dental Assistance. Dental Assistance is not intended to pay everything, but to assist with the costs of dental treatment. Generally, dental assistance pays a percentage of each procedure up to a set yearly maximum. The assistance available to you is established by which plan or package your employer has purchased.

As a courtesy to you, we will submit claims to your dental plan carrier. We also accept benefit assignment, meaning that payment will be sent to your office. We will ESTIMATE the expected benefit payment and allow you to pay your ESTIMATED PORTION at the time services are provided. However, we do not guarantee any estimate, and should your dental plan pay less than expected, you are fully responsible for the balance. We take no responsibility for any denials or exclusions by dental plans.

By signing below, I am stating that I understand and agree to these policies.

Authorized Signature \_\_\_\_\_

Date \_\_\_\_\_