JERRY BOYD, DDS, PC
WELCOME TO OUR PRACTICE

Patient Information

First Name:_____ Middle Name:_____ Last Name:_____

Address:_____ Address 2:_____

City:_____ State_____ Zip:_____

Home Phone:_____ Cell:_____ Work Phone:_____ Ext:_____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date:_____ Age:____ Soc. Sec:_____ Drivers License:_____

E-mail:_____

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Employer:_____ Address:_____

Student Status: ◯ Full Time ◯ Part Time

School Name:_____ City & State:_____

Preferred Pharmacy:_____ Phone:_____

Patient is: ☐ Policy Holder ☐ Responsible Party

How did you hear about our practice?_____

Spouse and/or Parent Information

First Name:_____

Address:_____

City:_____ State_____ Zip:_____

Home Phone:_____ Cell:_____ Work Phone:_____ Ext:_____

Birth Date:_____ Soc. Sec:_____ Drivers License:_____

Responsible Party (if someone other than patient)

First Name:_____ Middle Name:_____ Last Name:_____

Address:_____

City:_____ State_____ Zip:_____

Home Phone:_____ Cell:_____ Work Phone:_____ Ext:_____

Birth Date:_____ Soc. Sec:_____ Drivers License:_____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Primary Insurance Information

Name of Insured:_____ Relationship to Patient: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc Sec:_____ Insured Birth Date:_____

Employer:_____ Ins. Company:_____

Address:_____ Address:_____

City, State, Zip:_____ City, State, Zip:_____

Phone:_____ Phone:_____

JERRY BOYD, DDS, PC

ABOUT FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

If you have dental or medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment is due at the time services are rendered. We accept cash, check and most major credit cards. We will be happy to process your insurance claim for you as we accept assignment of insurance benefits, however, we ask that payment for any out-of-pocket expenses be paid at the time of treatment. **IN ALL CIRCUMSTANCES THE PATIENT IS RESPONSIBLE FOR ALL COSTS NOT PAID BY THE INSURANCE COMPANY.**
Returned checks and balances older than 30 days will be subject to additional collection fees (and interest charges of 1 1/2% per month). Charges may also be made for broken appointments and appointments cancelled without 24 hours advance notice.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. It is your responsibility to be sure your insurance is in effect and up to date.

2. Our fees are generally considered to fall within the acceptable range by most companies and therefore are covered up to a maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "U.C.R.". "U.C.R." is defined as usual, customary and reasonable fees for this region. Thus, our fees are considered usual, customary and reasonable by most companies. Please understand the amount we figure is only an estimate.
   This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While filing insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

Responsible Party and/or Patient Signature Date

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No _____

Have you recently been hospitalized or had a major operation? ◯ Yes ◯ No List: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No List: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Do you use tobacco? ◯ Yes ◯ No _____

Are you allergic to any metals? ◯ Yes ◯ No List: _____

Are you taking any prescription or over the counter drugs? ◯ Yes ◯ No List: _____

_____

_____

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other _____

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chemotherapy	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alcohol Abuse	☐ Chest Pains	☐ Glaucoma	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Cold Sores/Fever Blisters	☐ Hay Fever	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Congenital Heart Disorder*	☐ Heart Attack/Failure	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Murmur*	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Pace Maker*	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve*	☐ Drug Abuse	☐ Heart Trouble/Disease	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Artificial Joint*	☐ Easily Winded	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Asthma	☐ Emphysema	☐ Hepatitis A	☐ Psychiatric Care	☐ Tuberculosis
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tumors or Growth
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Herpes/Fever Blisters	☐ Recent Weight Loss	☐ Ulcers
☐ Breathing Problem	☐ Excessive Thirst	☐ High Blood Pressure	☐ Renal Dialysis	☐ Yellow Jaundice
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ Hives or Rash	☐ Rheumatic Fever*	
☐ Cancer	☐ Frequent Cough	☐ Hypoglycemia	☐ Rheumatism	

*Condition may require medication

Have you ever had any serious illness not listed above ◯ Yes ◯ No _____

Are you being treated for osteoporosis? ◯ Yes ◯ No

Have you taken any of the drugs listed below? For how long? For what treatment? _____

Oral:
- Actonel (risedronate) Yes ◯ No ◯
- Boniva (ibandronate) Yes ◯ No ◯
- Fosamax (alendronate) Yes ◯ No ◯
- Fosamax Plus D (alendronate) Yes ◯ No ◯
- Skelid (tiludronate) Yes ◯ No ◯
- Didronel (etidronate) Yes ◯ No ◯

IV:
- Aredia (pamidronate) Yes ◯ No ◯
- Zometa (zolendronate) Yes ◯ No ◯
- Bonefos (clodronate) Yes ◯ No ◯

DENTAL HISTORY

Why have you come to the dentist today?_____

Are you currently in pain ◯ Yes ◯ No

How long since your last dental cleaning?_____

Have you ever had a serious/difficult problem associated with any previous dental work? ◯ Yes ◯ No

Do you or have you ever experienced discomfort/pain in your jaw joint (TMJ/TMD)? ◯ Yes ◯ No

Your current dental health is ◯ Good ◯ Fair ◯ Poor

Do you like your smile? ◯ Yes ◯ No

Do your gums ever bleed? ◯ Yes ◯ No

Are your gums swollen and/or tender? ◯ Yes ◯ No

How many times a WEEK do you floss? _____

How many times a DAY do you brush? _____

Types of bristles? ◯ Hard ◯ Medium ◯ Soft

Do you have pain with brushing? ◯ Yes ◯ No

Do you have pain in your jaw joints? ◯ Yes ◯ No

Do you have bad breath even with regular brushing and/or mouthwash? ◯ Yes ◯ No

Do you have dry mouth? ◯ Yes ◯ No

Are you a mouth breather? ◯ Yes ◯ No

Are you aware of any sores or growths in your mouth? ◯ Yes ◯ No

Do you grind your teeth? ◯ Yes ◯ No

Do you bite your fingernails? ◯ Yes ◯ No

Do you regularly collect food between any of your teeth? ◯ Yes ◯ No

Do you have any loose teeth? ◯ Yes ◯ No

Do you have any broken fillings? ◯ Yes ◯ No

Are any teeth sensitive to heat, cold or sweets? ◯ Yes ◯ No

Are any teeth tender to bite on? ◯ Yes ◯ No

Have you had orthodontic treatment? ◯ Yes ◯ No

Have you had periodontal treatment? ◯ Yes ◯ No

Are you concerned about the health effects of metal fillings? ◯ Yes ◯ No

Are you concerned about the appearance of metal fillings? ◯ Yes ◯ No

Are you interested in preventive treatment against decay? ◯ Yes ◯ No

Are you interested in improving the appearance of your smile? ◯ Yes ◯ No

Are you interested in whitening your teeth? ◯ Yes ◯ No

To the best of my knowledge, the questions on this form have been accurately answered. i understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT , OR GUARDIAN DATE