Victory DENTAL GROUP

MEDICAL/DENTAL HISTORY AND INFORMATION
Please fill out as accurately as possible. Please print.

Personal Information

Patient Name:_____ Date of Birth:_____
Gender: Male_____ Female_____ Parent/Legal Guardian:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____
Email:_____ SS#:_____
How did you hear about us:_____

INSURANCE INFORMATION / RESPONSIBLE PARTY

Insurance Company:_____
Employer:_____ Primary Plan:_____
Policy Holder's Date of Birth:_____ Social Security Number:_____
Policy Number:_____

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

Y/N	Y/N	Y/N
☐ ☐ Anaphylaxis	☐ ☐ High/Low Blood Pressure	☐ ☐ Nervous Disorder
☐ ☐ Arthritis	☐ ☐ Hepatitis (A, B, C)	☐ ☐ Pacemaker
☐ ☐ Artificial Heart Valve	☐ ☐ Jaundice or Liver Disease	☐ ☐ Rheumatic Fever, Scarlet Fever
☐ ☐ Blood Disorder, Anemia, Problems	☐ ☐ Herpes	☐ ☐ Seizures e.g. Epilepsy, Stroke
☐ ☐ Clotting	☐ ☐ Hormone Disorder e.g. Thyroid Disease	☐ ☐ Sinus Trouble
☐ ☐ Cancer/Tumors	☐ ☐ HIV Infection/AIDS	☐ ☐ Tonsillitis
☐ ☐ Cold Sores/Fever Blisters	☐ ☐ Hives or Rash	☐ ☐ Tuberculosis
☐ ☐ Congenital Heart Disorder, Heart	☐ ☐ Joint Replacements	☐ ☐ Ulcers
☐ ☐ Murmur	☐ ☐ Pain in Jaw Joints	☐ ☐ Do you smoke or chew tobacco?
☐ ☐ Diabetes Type	☐ ☐ Kidney Disease	☐ ☐ Do you have a history of substance abuse?
☐ ☐ Fainting Spells	☐ ☐ Lung or Breathing Disorder, Asthma, Hay Fever	☐ ☐ Cannibis Use?
☐ ☐ Heart Condition	☐ ☐ Mitral Valve Prolapse	☐ ☐ Are you pregnant? ____How many weeks?

If you answered YES to any of the above, please explain any further details:_____

_____

Any other illness or procedures not listed here:_____

Medications presently taking:_____

(Please list)_____

_____

ALLERGIES

☐ None	☐ Codeine	☐ Latex
☐ Aspirin	☐ Local Anesthetics	☐ Metal
☐ Penicillin	☐ Acrylic	
	☐ Sulfa Drugs	

Other_____

In Case of Emergency

Last Name, First: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

HIPAA PATIENT CONSENT

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A detailed description of the HIPAA policy is available for your review upon request.

May we leave a recorded message regarding your financial responsibilities on your home or cell phones? Yes ☐ No ☐

May we e-mail health information to you? Yes ☐ No ☐

Signature: _____

This consent was signed by: ☐ Patient ☐ Parent ☐ Guardian Date Signed: ____/_____/_____

CONSENT FOR TREATMENT

I hereby authorize Victory Dental Group to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and medical history form are correct to the best of my knowledge.

Signature of Patient, Parent or Guardian_____ Date _____

OFFICE FINANCIAL POLICY

1. Our office provides insurance claim submissions as a courtesy to our patients. You are directly responsible to the doctor for your account irrespective of your insurance schedule.
2. If you don't have insurance, or you carry an insurance that does not reimburse our office, charges for services are due and payable at the time services are rendered.
3. We accept cash, personal checks and Visa, MasterCard, Discover, and American Express credit cards, as well as care credit.
4. I agree to pay a $40.00 fee on all returned or cancelled checks.
5. I understand that there is a no show/cancellation fee for all appointments. The fee is $50 per scheduled hour. No fee will be charged if appointment is cancelled with a 48 hour notice.

I authorize and request my insurance company to pay insurance benefits directly to the dentist or dental group. I understand that my dental insurance carrier may pay less than the actual bill for services and that I will be responsible for payment of all services rendered on my behalf. 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_____