

Please check any of the following which you have now or have had in the past. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked questions concerning your response.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> HIV infection/AIDS | <input type="checkbox"/> Cosmetic Surgery | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Fever Blisters/Cold Sores |
| <input type="checkbox"/> HIV positive/AIDS | <input type="checkbox"/> Fainting | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Arthritis/Rheumatism |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Anxiety Disorder |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic/Scarlet Fever | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Shingles | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Blood Disease | Describe: _____ | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Swelling, feet/ankle | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis (type) _____ | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> High/low Blood Pressure | <input type="checkbox"/> Tobacco Habit | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Liver Disease (Jaundice) | | |
| <input type="checkbox"/> Cough, Persistent | | | |

Is there anything else you would like us to be aware of? _____

Are you being treated for any illness now? (Circle) **NO** **YES** if yes, please explain: _____

Please list any allergies you have: _____

Women: Are you pregnant? **NO** **YES**
If no, are you planning a pregnancy in the near future? **NO** **YES**
Are you nursing? **NO** **YES**
Are you taking birth control pills? **NO** **YES** if yes, please list: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release information to you. I will notify the dentist of any changes in my health or medications.

Patient's Signature: _____ **Date:** ____/____/____

Financial Policy Agreement

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve. We are always available to answer your questions or assist you in any way we can. **Payment Options:**

- Full Pay Cash Discount:** We offer a 10% accounting courtesy for all treatment that is paid in full (cash/credit/check) at the time of service.
- 2 Payment Option:** We offer a two-payment option for Crown, Bridge, and Denture treatment. We ask that you pay one-half of your co-payment at the first appointment and the second half at the second appointment.
- Credit Card Payment Option:** We allow (with a signed agreement form), a Credit Card Payment option, this allows you to make three equal installments by credit card. One-third payment is due at the first appointment, one-third is due thirty days later, and the remaining one-third is due sixty days from the initial appointment. Our office staff will charge these payments to your credit card on the due dates.
- CareCredit:** We offer our patients, upon approval, a financing program with no down payment, several different payment options which are customized to your individual needs and no prepayment penalty. Please ask for an application.

To maintain the practice operations and to prevent potential misunderstandings, we ask patients to accept and adhere to financial arrangements regarding their dental treatment. **Payments are expected at the time services are rendered.** We accept cash, checks, ATM cards, and all major credit cards.

Broken appointments: This time has been reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hours notice to avoid a **\$50.00** cancellation fee.

Acknowledgment Receipt of Notice of Privacy Practices

I, _____, have received a copy of the 4th & Morris Dentistry Privacy Practice, (Print Name)
Financial Policy and I authorize the assignment and release form.

Patient's Signature

Date

If patient is a minor: Parent/Guardian's Signature

Date

