Ray of Smiles Dentistry

Medical History Form **Date**_____

Name_____ Home Phone (____)_____
Last First Middle

Address_____Business Phone (____)_____
Number, Street

City _____State_____Zip Code_____email_____

Occupation_____Social Security No._____

Date of Birth_____/_____/_____ Sex: M F Height_____Weight_____Single_____Married_____
mo day year

Name of Spouse_____ Emergency Contact_____ Phone (____)_____

If you are completing this form for another person, what is your relationship to that person?_____

Referred by_____

Although dental professionals primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with your oral health and the dental care you will receive. Thank you for answering the following questions. Please circle Yes or No. If you answer yes to any question, please explain.

Are you under a physicians care? Yes No If yes:_____

Have you ever been hospitalized or had a major operation? Yes No If yes:_____

Have you ever had a serious head or neck injury? Yes No If yes:_____

Are you taking any prescriptions or over-the-counter medications? Yes No If yes, please list below:

Do you take anti-coagulant medications (blood thinners)? Yes No If yes:_____

Have you ever had joint replacement, heart valve replacement or a congenital heart defect? Yes No

If yes:_____

Are you required to take premedication (antibiotics) for any condition such as joint replacement or a heart condition? Yes No If yes:_____

Have you ever taken bisphosphonate medications for osteoporosis: Yes No If yes:_____

Current tobacco use? Yes No If yes:_____

Previous tobacco use? Yes No If yes:_____

Do you wear contact lenses? Yes or No Do you wear removable dental appliances? Yes or No

---

Allergies: Are you allergic to any of the following? Check all that apply.

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Allergic to anything not listed above? Yes No If yes, please explain:

Do you have, or have you had, any of the following? Check all that apply.

High Blood Pressure	◯ Yes	◯ No
Low Blood Pressure	◯ Yes	◯ No
Heart Attack	◯ Yes	◯ No
Stroke	◯ Yes	◯ No
Chest Pain/Angina	◯ Yes	◯ No
Congestive Heart Failure	◯ Yes	◯ No
Heart Valve Replacement	◯ Yes	◯ No
Pacemaker	◯ Yes	◯ No
Irregular Heartbeat	◯ Yes	◯ No
Anemia	◯ Yes	◯ No
Hemophilia	◯ Yes	◯ No
Congenital Heart Defect	◯ Yes	◯ No
Asthma	◯ Yes	◯ No
COPD	◯ Yes	◯ No
Breathing Problems	◯ Yes	◯ No
Frequent Cough	◯ Yes	◯ No
Stomach/Intestinal Disease	◯ Yes	◯ No
Acid Reflux/GERD	◯ Yes	◯ No
Arthritis	◯ Yes	◯ No
Artificial Joint	◯ Yes	◯ No
Osteoporosis	◯ Yes	◯ No
Diabetes	◯ Yes	◯ No
Excessive Thirst	◯ Yes	◯ No
Low Blood Sugar	◯ Yes	◯ No
Liver Disease	◯ Yes	◯ No
Thyroid Disease	◯ Yes	◯ No
Kidney Disease	◯ Yes	◯ No

Renal Dialysis	◯ Yes	◯ No
Parathyroid Disease	◯ Yes	◯ No
Recent Weight Loss	◯ Yes	◯ No
Cancer	◯ Yes	◯ No
Tumor or Growth	◯ Yes	◯ No
Chemotherapy	◯ Yes	◯ No
Radiation Treatment	◯ Yes	◯ No
Excessive Bleeding	◯ Yes	◯ No
Blood Transfusion	◯ Yes	◯ No
Alzheimer's/Dementia	◯ Yes	◯ No
Fainting Spells	◯ Yes	◯ No
Dizziness	◯ Yes	◯ No
Shortness of Breath	◯ Yes	◯ No
Mental Health Problems	◯ Yes	◯ No
Drug Addiction	◯ Yes	◯ No
Cold Sores/Fever Blister	◯ Yes	◯ No
Shingles	◯ Yes	◯ No
Tuberculosis	◯ Yes	◯ No
Hepatitis	◯ Yes	◯ No
HIV/AIDS	◯ Yes	◯ No
STD	◯ Yes	◯ No
Sinus Problems	◯ Yes	◯ No
Tonsillitis	◯ Yes	◯ No
Dry Mouth	◯ Yes	◯ No
Sore Jaw Muscles	◯ Yes	◯ No
Popping/Clicking in TMJ	◯ Yes	◯ No
Sleep Apnea	◯ Yes	◯ No

Women: Are you…..

☐ Pregnant/Trying to pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Comments:

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 my medical status.

Signature of Patient, Parent or Guardian:

X_____Date:_____

Barry W. Ray, DDS, MAGD

Mary J. Miles, DMD Joseph W. King, DDS

OFFICE FINANCIAL POLICY

"Quality... is never an accident. It is always the result of high intention, sincere effort, and skillful execution. It represents the wise choice of many alternatives."

Thank you for choosing us as your dental care provider. Our primary goal is to help you keep your teeth for a lifetime. Your comfort, appearance and long-range dental health needs will be kept in mind at all times. When treatment is indicated, we will try to restore optimum dental health in as few, well-planned appointments as necessary. We recognize the value of your time.

Except in emergency situations, you can expect us to be on time for you. We would appreciate the same courtesy. Therefore, we need your assistance and understanding of our office financial policy as follows:

1. Payment is expected at the time of service, and may be made by cash, checks, credit card, post-dated check, or financing (see us for financing details and information on CareCredit). Credit checks may be performed at our discretion.
2. For multiple appointment treatment, **one-half** is payable the first appointment and **one-half** is payable the last appointment. If the entire fee is paid on the first appointment, a 5% discount will be given.
3. Senior citizens will be given a 10% discount.
4. If an insurance company or other plan is assisting you in payment, the above discounts do NOT apply. **Insurance laws prohibit us from offering discounts on co-pays and out-of-pocket expenses to our insured patients.**
5. Missed appointments may be charged a $25.00 fee at our discretion.
6. Insurance benefits are an estimated aid; therefore, estimated co-payments **will be collected on the day of service.**

   You must provide insurance information including **claim address and coverage details**. If you cannot provide the needed information on or before your appointment, you will be responsible for the full fee and must wait for your insurance company's reimbursement.

   Your insurance is a contract between you and the insurance company. We are NOT a party to that contract; however, we are happy to file insurance claims on our patients' behalf. Not all services are a covered benefit. Insurance companies arbitrarily select the services they will not cover.

   Any account balance 60 days overdue will be billed at 1.5% interest per month.

7. **Hoosier Accounts** will be given any inactive account 90 days past due.
8. Returned checks are subject to bank charges and a $30.00 service charge.

If you have any questions or are uncertain about the information, ***please*** don't hesitate to ask us. **We are here to help!**

I understand and agree that, regardless of my insurance, I am responsible for the balance of my account for any professional services rendered. I have read and understand all the information on this sheet.

NAME (Please Print)_____DATE_____

SIGNATURE_____DATE_____

PARENT OR GUARDIAN_____DATE_____

"A Friend of the Family"

Barry W. Ray, D.D.S., M.A.G.D
Mary J. Miles, D.M.D
Joseph W. King, D.D.S.
Informed Consent

Informational Purposes Only *Obtain Legal Counsel*

General Consent for Treatment

All dental and anesthetic procedures have associated risks. These may be, but are not limited to:

- *Drug reactions and side effects.*
- *Damage to adjacent teeth or fillings.*
- *Post-operative infection.*
- *Post-operative bleeding that might require additional treatment.*
- *Delayed healing of an extraction site, (dry socket) necessitating additional care.*
- *Sinus involvement during removal of upper teeth which may require additional treatment or surgical repair at a later date.*
- *Swallowing or aspiration (inhalation into the respiratory system) of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. resulting in the need for further medical treatment.*
- *Changes to the treatment plan due to conditions discovered during treatment that were not evident at the time of examination. (For example, root canal therapy following routine restorative procedures resulting in the need for additional treatment)*
- *Involvement of the nerves during removal of teeth resulting in temporary or possibly permanent numbness or tingling of the lip, chin, tongue, or other areas.*
- *Bruising, hematoma, swelling, sensitivity or pain.*
- *Failure of the dental procedure necessitating additional treatment.*
- *Breakage of dental instruments inside tooth canals making additional treatment necessary.*

I understand there may be associated risks for any recommended treatment, as well as the consequences of doing nothing. I understand that dentistry is not an exact science and therefore my dental practitioner cannot properly guarantee results. I acknowledge that no guarantee or assurances have been made by anyone regarding dental treatment.

Date: _____

Patient Signature: _____

Barry W. Ray, D.D.S., M.A.G.D.
Mary J. Miles, D.M.D.
Joseph W. King, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices

Please Print Name

Signature

Date