BACKHUS
FAMILY DENTISTRY

PATIENT INFORMATION

Name_____Soc. Sec.#_____
Last Name First Name Middle
Name you go by_____ Spouses name/(Child: Parent's name)_____
Address_____
City_____State_____Zip code_____
Birth date_____ ☐ Single ☐ Married ☐ Widowed ☐Separated ☐ Divorced
Patient/Guardian employed by_____Occupation_____
Home phone_____ Cell phone_____ Business phone_____
Email address_____
Business address_____
Present position_____ How long?_____
Whom may we thank for referring you to our office?_____
In case of emergency, who should we notify?_____ Phone_____

INSURANCE

Person responsible for account_____
Last Name First Name Middle
Relationship to patient_____ Birth date_____Soc. Sec.#_____
Address (if different from patient's)_____Phone_____
City_____State_____ Zip code_____
Person responsible employed by_____ Occupation_____
Business address_____Business phone_____
Insurance company_____
Contract#_____Group#_____Subscriber#_____
Names of other dependents under this plan_____
Is patient covered by additional insurance? Yes___ No____
Subscriber name_____ Relationship to patient_____ Birth date_____
Insurance company_____Soc. Sec.#_____
Group#_____Subscriber#_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance with _____
Name of insurance company
and assign directly to Mark E. Backhus, D.D.S. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

HEALTH HISTORY

DENTAL HISTORY

Reason for today's visit_____

Previous dentist_____Address_____

Date of last dental care_____ Date of last dental x-rays_____

Do you have problems with any of the following?

Y	N	Bad breath	Y	N	Clenching teeth	Y	N	Sensitivity to hot
Y	N	Bleeding gums	Y	N	Loose fillings	Y	N	Sensitivity to sweets
Y	N	Clicking or popping jaw	Y	N	Broken fillings	Y	N	Discomfort when biting
Y	N	Food collection between teeth	Y	N	Recent dental pain	Y	N	Sores or growths in your mouth
Y	N	Grinding teeth	Y	N	Sensitivity to cold			

How often do you floss?_____ How often do you brush?_____

MEDICAL HISTORY

Physician's name_____ Physician's phone_____ Date of last visit_____

I. **CIRCLE APPROPRIATE ANSWER (leave BLANK if you do not understand the question):**

Y N Is your general health good?
Y N Has there been a change in your health within the last year?
Y N Have you ever been hospitalized or had a serious illness?
If yes, describe._____

Y N Are you being treated by a physician now? For what? _____

Women:
Y N Are you pregnant? Y N Are you nursing? Y N Are you taking birth control pills?

II. **DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?**

Y	N	Abnormal bleeding	Y	N	Epilepsy	Y	N	Respiratory disease
Y	N	AIDS	Y	N	Fainting	Y	N	Rheumatic fever
Y	N	Anemia	Y	N	Glaucoma	Y	N	Scarlet fever
Y	N	Arthritis, Rheumatism	Y	N	Headaches	Y	N	Shortness of breath
Y	N	Artificial heart valves	Y	N	Heart murmur	Y	N	Sinus trouble
Y	N	Artificial joint	Y	N	Heart problems	Y	N	Skin rash
Y	N	Asthma	Y	N	Hepatitis (Type___)	Y	N	Stroke
Y	N	Back problems	Y	N	Herpes	Y	N	Swelling of feet or ankles
Y	N	Blood disease	Y	N	High blood pressure	Y	N	Swollen neck glands
Y	N	Cancer	Y	N	HIV positive	Y	N	Thyroid problems
Y	N	Chemical dependency	Y	N	Jaundice	Y	N	Tuberculosis
Y	N	Chemotherapy	Y	N	Jaw pain	Y	N	Tumor or growth on head or neck
Y	N	Circulatory problems	Y	N	Kidney disease			
Y	N	Congenital heart defects	Y	N	Liver disease	Y	N	Use of bisphosphonates
Y	N	Contact lenses	Y	N	Mitral valve prolapse	Y	N	Ulcer
Y	N	Cortisone treatments	Y	N	Nervous problems	Y	N	Venereal disease
Y	N	Cough, persistent	Y	N	Pacemaker	Y	N	Weight loss (unexplained)
Y	N	Diabetes	Y	N	Psychiatric care			
Y	N	Emphysema	Y	N	Radiation treatment			

III. **HAVE YOU EVER USED?** Y N Tobacco in any form Y N Alcohol Y N Recreational drugs

IV. Do you or have you had any other diseases or medical problems NOT listed on this form?
If so, please explain:_____

MEDICATIONS	ALLERGIES
List all medications you are currently taking _____ _____ _____	Yes No Aspirin Yes No Penicillin Yes No Codeine Yes No Sulfa Yes No Local Anesthetics Yes No Latex Other_____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Print Patient Name:_____

Patient/Guardian Signature_____ Dentist Initials_____ Date_____

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Office Financial Policy

Thank you for choosing our office. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of this mission is making the cost of optimal care as easy and affordable for our patients as possible by offering several payment options. If you have dental insurance we are here to assist you in receiving your maximum allowable benefits.

We accept cash, personal checks, Mastercard, Visa, American Express, Discover and Care Credit. In addition, we offer an excellent third party financial payment plan. Our office staff would be happy to provide you with more detailed information on this plan if you are interested.

As a courtesy to our patients, we will submit your insurance claims for you. However, it is important to understand that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. We do not provide services on the assumption the charges will be paid by an insurance company. All charges are your responsibility from the date the services are rendered.
3. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Per California law, the patient will be billed the full usual and customary rate for any non-covered services.

You may direct your dental insurance company to pay their share of the cost to our office (Assignment of Benefits). Often, payments for claims submitted to your dental insurance company are not received in a timely manner. We, therefore, request that you pay your estimated share at the time of treatment. Upon receipt of payment from your insurance company, we will reconcile your account. At this time we will send you a bill or a refund for any difference.

We would like to emphasize that as dental care providers, our relationship is with you, the patient, and not your insurance company. While filing insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered.

In an effort to schedule everyone in a timely manner, we ask that you please give us a minimum 24 hour notice if you need to reschedule your appointment. Please see our cancellation/missed appointment policy for details.

All outstanding balances over 90 days will be assessed an 18% service charge.

If you have any questions about our financial policy, please do not hesitate to ask us. We are here to assist you.

_____

Patient Name

_____ _____

Patient/Guardian Signature Date

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Cancellation and Missed Appointment Policy

We understand that you may sometimes need to reschedule your appointment due to extenuating circumstances. A cancellation made with less than 24 hour notice significantly limits our ability to make the appointment available for another patient in need. As such, we have implemented the following cancellation and missed appointment policy:

Hygienist (Exams, Cleanings, X-rays) $75

Hygienist (Deep cleaning/Root planing) $100

Dr. Mark (All other treatment) $125

1. Please provide our office a 24-hour notice in the event that you need to reschedule your appointment. This will allow us the opportunity to provide care to another patient. To avoid the cancellation fee, please contact us by phone, text, email, or leave a message on the answering machine.

2. The cancellation fee is not billable to your insurance.

3. If you are more than 15 minutes late for your appointment, the appointment may need to be rescheduled.

4. As a courtesy, we make reminder calls for appointments one to two days in advance. Please note, if a reminder call or message is not received, the cancellation policy remains in effect.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you may have.

_____

Patient Name

_____ _____

Patient/Guardian Signature Date