Welcome to Three Fountains Dentistry

"A True Family Practice"

Patient Information

Date:_______________

Patient Full Name: ________________________ Preferred Name:__________________________ DOB:_______________

SSN:_______________ Sex: M/F Martial Status: M/ S/ W/ D Email:__________________________________

Address:____ City:____________________ State_______ Zip:_________

Home Phone:___________________ Cell Phone:________________________ Work Phone:__________________

Employer:__________________________ Occupation:______________________ Yrs Employed:_______________

Emergency Contact Name:_______________________________ Emergency Contact Phone:_________________

Relationship to Patient:_______________________________

How Did You Hear about Us? ____

Responsible Party Information (If different from Patient)

Responsible Party Name:______________________________ Relationship to Patient:_______________________

DOB: _______________ SSN:______________ Email:______________________ Phone Number:____________________

Address:_______________________________________ City:______________________ State:_____________ Zip:_________

(If Child, Mom's Name:_______________________________ Dad's Name: ______________________________)

Dental Insurance Information

Primary Insurance

Insured's Name:____________________________ Relationship to Patient:___________________________________

DOB:_______________ SSN:___________________ Employer:____

Insurance Company Name:______________________________ Insurance Phone:_____________________________

Address:_______________________________________ City:____________________ State:________ Zip:_______________

Insurance Member ID:___________________________________ Group #:_______________________________________

Secondary Insurance

Insured's Name:____________________________ Relationship to Patient:___________________________________

DOB:______________ SSN:_____________________ Employer:____

Insurance Company Name:______________________________ Insurance Phone:_____________________________

Address:_______________________________________ City:____________________ State:________ Zip:_______________

Insurance Member ID:___________________________________ Group #:_______________________________________

Adult Health History Form

Name: ____ **Date of last Dental Visit:** ________________

Please Circle the Following

1. Do you have any current dental concerns? YES NO
   If yes, explain: ____
2. Have you been admitted to the hospital or needed emergency medical care in the past 2 years? YES NO
   If yes, explain: ____
3. Are you currently, or have you been in the last two years, under the care of a medical Doctor? YES NO
   Physician's Name: ______________________ Office Number: ______________________
4. Have you taken any medications or drugs in the past two years? YES NO
5. Are you now taking any medications, drugs or pills? YES NO
   If yes, please list: ____
6. Have you taken the diet drug Phen-Fen? YES NO
   If yes, have you seen your cardiologist for a cardiac evaluation? YES NO
7. Have you ever taken Fosamax, Actonel, Boniva or any other drug(s) prescribed to decrease the resorption of bone, as in osteoporosis or any other drug(s) for metastatic bone cancer? YES NO

Please Circle the Following you HAVE HAD or HAVE CURRENTLY

Heart Disease or Attack	Thyroid Problems	Bruise Easily	Congenital Heart Disease
Hives	Glaucoma	Epilepsy or Seizures	*Heart Murmur
Cancer	Fainting or Dizzy Spells	High / Low Blood Pressure	Radiation Therapy
Nervousness	*Artificial Heart Valve	Chemotherapy	Developmentally Disabled
Emphysema	Excessive Thirst	Heart Surgery	Chronic Cough
Alzheimer's Disease	*Rheumatic Fever	Blood Transfusion	Arthritis
Any kind of Glandular Disorder	Cortisone / Steroid	Drug Addiction	Blood Disease
Stroke	Seasonal Allergies/Hay Fever	Sinus Trouble	Hemophilia
Shortness of Breath	Anemia		
Cold Sores / Fever Blisters	Sickle Cell Disease		
Pain in Jaw Joints	Hypoglycemia		
Hepatitis	Heart Pacemaker		
*Artificial Joints	Yellow Jaundice		
Kidney Trouble	Venereal Disease		
Ulcers	A.I.D.S		
Diabetes	H.I.V. Positive		
Tuberculosis	Asthma		

Are you allergic to any of the following:

Codeine	YES	NO
Aspirin	YES	NO
Erythromycin	YES	NO
Nitrous Oxide	YES	NO
Novacaine / Local Anesthetic	YES	NO
Penicillin	YES	NO
Percodan	YES	NO
Sulfa	YES	NO
Valium	YES	NO
Tetracycline	YES	NO
Acetaminophen	YES	NO

WOMEN ONLY

- Are you taking birth control pills? YES NO
- Are you pregnant? YES NO
  If Yes, Due Date: __________________
- Are you nursing? YES NO

ARE YOU ALLERGIC TO LATEX?

YES NO

8. Are you allergic to any medications or anesthetics not listed Above? YES NO
   If yes, please list: ____
9. Do you have or have you had any disease, condition, or problem not listed above? YES NO
   If yes, explain: ____
10. Do you use tobacco or alcohol products? YES NO
11. Have you ever had any complications following dental treatment? YES NO
    If yes, explain: ____

I herby Certify that the answers to the questions above are accurate to the best of my knowledge. Since a change in medical condition or medication can affect my dental treatment, I understand the importance of and agree to take responsibility for notifying the Doctor of any changes at any subsequent appointment.

Patient, Legal Guardian or Authorized Agent Signature: ______________________________________ Date: _______

OFFICE FINACIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. Patient co-payments (the amount not covered by insurance) are due and payable at time of service.

All emergency dental services, or any dental service performed without previous financial arrangements, must be paid for at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients and assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A service charge of 1.5% per month (18% per annum) on unpaid balance will be assessed on all accounts exceeding sixty(60) days from the date of service. Fee estimates for dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for professional services rendered to me, or at my request for a minor child or ward, by the dentist, I agree to pay the reasonable value of said services to said dentist or his assignee at the time said services are rendered, or within thirty(30) days of billing if credit shall be extended. I further agree that the reasonable values of said services shall be billed unless objected by me in writing, within the time for payment thereof. I further agree that a waiver of any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit is instituted hereunder to collect monies owed by me, including interest charges, processing fees or commissions (up to 50% of principle) that may be assessed by any collection agency retained to pursue this matter.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matter relating to this form. I further agree that if I cannot be contacted related to these matters my emergency contact(s) may be contacted, with utmost discretion, to ascertain my whereabouts.

I authorize assignment or payment of all dental and/or surgical benefits to which I or other family members are entitled, including private dental insurance and other group health plan benefits otherwise payable to the undersigned, to Mark S. Cannon, DMD. I certify that I have read and answered all questions on the forms accurately and hereby agree by all conditions outlined therein.

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Signature of Patient, Parent or Guardian	**Date**	**Relationship to Patient**

Consent To Proceed

I authorize **Dr. Mark Cannon** and/or such associates or assistants as he may delegate, to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including Nitrous Oxide), analgesic, other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand the administration of local anesthetic may cause untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles may break and may require surgical retrieval.

I understand that as part of dental treatment, including preventative procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or possibly quite painful both during and after completion of treatment. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me as necessary and I have been given the opportunity to ask questions.

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Patient Name **Signature of Patient, Legal Guardian or Authorized agent of patient**

Date

CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our *Notice of Privacy Practices* provides information about how we may use and disclose protected health information about you. By signing this form, you consent to our use and disclosure of Protected Health Information about you for Treatment, Payment and Healthcare Operations. You have the right to revoke this consent in writing.

I hereby give consent for Mark S. Cannon, DMD to use my personal health information for Treatment, Payment and Healthcare Operations. (We will gladly provide you with a copy of the Notice of Privacy Practices for Mark S. Cannon, DMD upon request.)

Patient's Name (please print): ____

Signature: ____

Date: ______________________

***If this is signed by a personal representative on behalf of the patient, complete the following:*

Personal Representative's Name: ____

Relationship to Patient: ____

Three Fountains Dentistry

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