LAYTON
FAMILY DENTAL

*Welcome!* Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible Dental Care! To help us meet all your dental healthcare needs please fill out these forms completely. If you have any questions or need any assistance, please feel free to ask- we will be happy to help!

## Patient Information
(Confidential)

Name _____Date of Birth_____SSN#_____**M/F**
Address_____City_____State_____Zip_____
Home phone_____ Cell phone_____Marital Status_____

E-mail address_____ May we contact you via email?_____

Employer _____Work Phone _____
Business Address_____ City_____ State_____ Zip _____

Spouse's Name_____Employer_____Work ph._____

If Patient is a Student, Name of School, or College_____

## Responsible Party

Name of person responsible for this Account_____
Address_____Phone_____Relationship to patient _____
Is this person a patient here at our office?_____

## Insurance Information

Name of insured_____Relationship to patient_____

Date of Birth _____ SSN or Member ID_____

Name of Employer _____Work Phone _____

Business Address _____City_____State_____ Zip _____

Insurance Company _____Effective date_____Group #_____

Insurance Company Website_____Contact phone Number_____

Other family members that also have this insurance:_____

_____

***Do you have any additional insurance? Yes _____ No _____
If Yes please ask for additional insurance form.

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# Health History

Health Hx Updated On:_____
_____
_____

Physician:_____Office phone:_____Date of last Physical:_____

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Are you currently undergoing any medical treatment? If yes, for what condition?_____ |
| ☐ | ☐ | Have you had any major surgeries or illnesses within the last year? If yes, please explain:_____ |
| ☐ | ☐ | Are you currently taking any Medications? Please include non-prescription medications. Please list:_____ |
| ☐ | ☐ | Are you taking any vitamins or supplements on a regular basis? If yes please list: _____ |

**If female please answer the following:**

| Y | N | |
|---|---|---|
| ☐ | ☐ | Are you taking Birth Control Pills? |
| ☐ | ☐ | Are you pregnant? If Yes, # of weeks ☐ |
| ☐ | ☐ | Are you nursing? |

| Y | N | Conditions | Y | N | Conditions |
|---|---|---|---|---|---|
| ☐ | ☐ | Allergies/ Hayfever | ☐ | ☐ | HIV+ AIDS |
| ☐ | ☐ | Abnormal Bleeding | ☐ | ☐ | Heart Attack |
| ☐ | ☐ | Anemia | ☐ | ☐ | Heart Surgery |
| ☐ | ☐ | Angina Pectoris | ☐ | ☐ | Hemophilia |
| ☐ | ☐ | Arthritis | ☐ | ☐ | Hepatitis A |
| ☐ | ☐ | Artificial Heart Valve | ☐ | ☐ | Hepatitis B |
| ☐ | ☐ | Artificial Joints | ☐ | ☐ | Hepatitis C |
| ☐ | ☐ | Asthma | ☐ | ☐ | High Blood Pressure |
| ☐ | ☐ | Bisphosphonates (Fosamax, Boniva | ☐ | ☐ | Kidney Problems |
| ☐ | ☐ | Blood Transfusion | ☐ | ☐ | Liver Disease |
| ☐ | ☐ | Cancer- Chemotherapy | ☐ | ☐ | Low Blood Pressure |
| ☐ | ☐ | Congenital Heart Defect | ☐ | ☐ | Pace Maker |
| ☐ | ☐ | Diabetes Type 1 | ☐ | ☐ | Radiation Therapy |
| ☐ | ☐ | Diabetes Type 2 | ☐ | ☐ | Seizures |
| ☐ | ☐ | Difficulty Breathing | ☐ | ☐ | Shingles |
| ☐ | ☐ | Drug Abuse | ☐ | ☐ | Sickle Cell Disease |
| ☐ | ☐ | Emphysema | ☐ | ☐ | Sinus Problems |
| ☐ | ☐ | Epilepsy | ☐ | ☐ | Stroke |
| ☐ | ☐ | Fainting Spells | ☐ | ☐ | Thyroid Problems |
| ☐ | ☐ | Fever Blisters | ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | Frequent Headaches | ☐ | ☐ | Ulcers |
| ☐ | ☐ | Glaucoma | ☐ | ☐ | |

**Please answer the following:**

| Y | N | |
|---|---|---|
| ☐ | ☐ | Do you smoke? |
| | | ____ How many packs per day? |
| ☐ | ☐ | Do you use tobacco? |
| | | ____ How many times per day? |

| Y | N | Allergies |
|---|---|---|
| ☐ | ☐ | Aspirin |
| ☐ | ☐ | Codeine |
| ☐ | ☐ | Dental Anesthetics |
| ☐ | ☐ | Erythromycin |
| ☐ | ☐ | Jewelry |
| ☐ | ☐ | Latex |
| ☐ | ☐ | Metals |
| ☐ | ☐ | Penicillin |
| ☐ | ☐ | Tetracycline |
| ☐ | ☐ | Sulfa |

Other _____

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# Dental History

When was your last dental visit? _____What was done then? _____

Have you ever been told you require Premedication prior to dental treatment? _____

If yes for what medical condition? _____

Do you have a specific problem which needs attention now? _____

Are any of your teeth currently bothering you? _____

Are any of your teeth sensitive to temperatures? _____

Are you apprehensive about receiving any dental treatment? _____

Do your gums bleed when brushing or flossing?_____

Have you had any TMJ (jaw joint) problems or sore jaw joints in the past? _____

Do you clench or grind your teeth? _____If yes, do you wear a night guard?_____

Have you ever had braces? _____ At what age?_____

Have you ever whitened your teeth? _____Would you like to learn more about it?____

Is there anything you would like to change about your smile? _____
_____

Whom May We Thank for Referring You to Our Office? _____

Person to contact in case of Emergency_____

Phone_____Relationship to you _____

**Signature_____Today's Date_____

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# Cancellation & Broken Appointment Policy

It is to the benefit of all our patients and our staff to know when someone is unable to attend their scheduled appointment. When you make an appointment, we will consider it a verbal contract between us. We will attempt to confirm your appointment 2 days prior to your scheduled time. For appointments that are scheduled for 2 hours or more we may request a call back for confirmation.

We do require at least **2 full days** notice to cancel or change your appointment, this will allow adequate time to schedule another patient in your appointment slot.
Any broken or failed appointment without the requested 2 Full Day notice will be charged a fee of $25. **Longer appointment times may be charged a per hour fee.

Thank you for your acknowledgment and consideration.

Dr. Aaron Layton DDS

I Have Received notice of Layton Family Dental's policy for Cancellation and Broken appointments.

Print your name_____

Patient Signature _____Date:_____

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# Financial Policy and Payment Options

Layton Family Dental strives to offer convenient payment options while at the same time maintaining the high standard of comprehensive dental care that our patients deserve. At the onset of treatment, we will provide you with an **estimate** of your total costs. Please understand that this will only be an **estimate**. If the need for additional treatment arises during the course of the original treatment plan the fees could change. *Be assured that we will notify you of fee changes and obtain your approval prior to proceeding with treatment.*

Our primary goal is to help you maximize your dental insurance benefits. As a courtesy, we are happy to to bill your dental insurance on your behalf. Please remember that the contract itemizing your dental benefits is between you, your employer and your insurance carrier. We only bill your insurance as a convenience for you. **Regardless of coverage, your estimated co-payment is due in full the day of treatment.** Any insurance claim not paid in full after 60 days will become your responsibility. Should the insurance pay at a later date then you will receive a refund check. Also remember that dental insurance plans are not designed to cover all of your dental expenses.

We accept most major credit cards, as well as checks and cash. We are also pleased to offer our patients an extended monthly payment plan option through a dental financing company. **CareCredit.** is able to extend credit for up to **6 months at 0% interest.** This must be arranged prior to receiving any treatment. Please ask our patient coordinator for an application or more details and a brochure with instructions on how to apply.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me and/or my child during the period of such dental care to a third party payer and/or health practitioners. I authorize and request that my insurance company pay directly to the dentist and/or dental group insurance benefits otherwise payable to me.

Furthermore, I accept full financial responsibility for this account and for all dentistry performed upon me and my dependents in this dental office. I understand that it is up to me to confirm my insurance eligibility, waiting periods, and benefits. I also understand that this office cannot guarantee my insurance status in these areas. Any insurance estimate or information given to me by this office is not a guarantee of of actual insurance payment. I also understand that any insurance claim not paid in full after 60 days will become my responsibility to pay at that time. **Any balance on my account after 60 days will accrue a 1.5% per month finance charge.**

**Patient Printed name**_____**Date:**_____

**Patient Signature**_____

# Acknowledgment of Receipt of Notice of Privacy Practices. (HIPPA)

*** You may refuse to sign this Acknowledgment

I, _____ Have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Your Name and the name of any dependents under 18

_____

Signature

_____

Date

_____

For office use only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgment

☐ An emergency situation prevented us from obtaining acknowledgment

☐ Other (please specify)

_____



This Form is educational only, does not constitute legal advice, and covers only federal, not state, law. (August 1