Favero Family Dental
3201 Teasley Ln. #101
Denton, TX 76210

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City/State: _____ Zip: _____ Phone: (____)_____

Cell Phone: (____)_____ E-mail Address: _____

Employer: _____ Business Phone :(____)_____

Occupation: _____ Physician: _____

Name of Spouse: _____ Phone: (____)_____

Employer: _____ Occupation: _____

Who may we thank for referring you to our office? _____

MEDICAL HISTORY - The following information is requested to thoroughly diagnose any relevant conditions and to give you our personal attention.

YES NO

___ ___ 1. Are you now, or have you been under a physician's care in the last five years for any major/ongoing condition? If yes, please explain: _____

___ ___ 2. Are you now taking any medication? This includes all over the counter drugs and oral contraceptives, as well as prescribed drugs. Please list: _____

_____

___ ___ 3. Do you have any allergies or are you sensitive to any drugs such as penicillin, novocaine, aspirin, or codeine? If yes, please explain: _____

___ ___ 4. Do you bleed excessively after a cut, wound, or surgery?

___ ___ 5. Are you subject to fainting, dizziness, nervous disorders, convulsions, or epilepsy?

___ ___ 6. Have you ever had breathing difficulty, such as asthma, emphysema, chronic cough, pneumonia, T.B., or other lung diseases? If yes, please explain: _____

___ ___ 7. Have you ever had any of the following diseases or conditions such as heart problems/prosthetic heart valve/heart valve problems? If yes, please explain: _____

___ ___ 8. Rheumatic fever?

___ ___ 9. Hepatitis/liver or kidney disease?

___ ___ 10. High or Low blood pressure?

___ ___ 11. Prosthetic Joint?

___ ___ 12. Diabetes?

___ ___ 13. Anemia?

___ ___ 14. Venereal Disease?

___ ___ 15. Any other infectious disease? Please list: _____

___ ___ 16. Tested positive for HIV?

DENTAL HISTORY:

1. Please comment about your previous dental experiences?

2. What is your main dental concern?

3. How do you feel about the appearance of your teeth?

Patient's Social Security #: _____ Driver's License #: _____

Name of Dental Insurance: _____ Insured's S.S. #: _____ Group #: _____

Person Responsible for Account: _____ Address: _____

***Any unpaid balance remaining after 60 days will be subject to a billing fee of 1.5% per month with a minimum fee of $5.00 per month.**

Signature: _____ Date: _____

(Please see reverse side)

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Most dental insurance plans will help you maintain a healthy mouth. However, dental insurance was never designed to allow for complete financial assistance in cases where moderate to extensive treatment is needed. **Most plans will cover 35-65% of services based in the plan's fee allowance, which varies widely from company to company.**

We are committed to providing you with the best possible care. If you have dental insurance, we would be pleased to assist you in receiving your maximum allowable benefits. To achieve these goals, we need your assistance and understanding of your financial arrangement with our office.

Payment for services is due at the time services are rendered, unless arrangements have been approved in advance. We will be pleased to assist you in processing your insurance claim for your reimbursement.

Our staff will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however:

1. Your insurance is a contract between you, your employer, and your insurance company.
2. Your employer has selected the level of insurance coverage. Not all services are covered benefits in all contracts. Some insurance companies select certain services they will not cover.

It is necessary to emphasize, as a dental care provider, our relationship is with you and not your insurance company. **While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.**

For your convenience, you may pay cash, check, Discover, Visa, or MasterCard.

If you have any questions about the above information, or any uncertainty regarding insurance coverage, please do not hesitate to ask. We are here to assist you.

Just a reminder: Accounts over 60 days will be subject to a 1.5% interest fee, or a minimum of $5.00, whichever is greater.

I acknowledge that I have read this information and understand the office policy.

Signature: _____ Date: _____

(Please see reverse side)