Stonewall Dental Associates

MEDICAL HISTORY/FINANCIAL AGREEMENT UPDATE

***Patient Name*: ____ *Date:* _________________________**

Family Dr. /Pediatrician ____ City/State _____________________________

Phone___________________________ Date of last visit _________

Have you ever had any illness or operations? □ yes □ no When? ___________ If yes, describe ____

Have you ever had a blood transfusion? □ yes □ no Date ________

Women: **Are you pregnant?** □ Yes □ No **Nursing?** □ Yes □ No **Taking birth control pills?** □ Yes □ No

Check (✓) if you have any of the following:

□ADD/ ADHD
□ AIDS/ HIV
□ Allergies / sinus problems
□ Anaphylaxis
□ Anemia
□ Arthritis / Rheumatism
□ Artificial heart valves
□ Artificial joints
□ Asthma
□ Autism
□ Blood Disorders
□ Cancer/ Tumors
□ Cerebral palsy
□ Chemotherapy
□ Circulatory problems
□ Cortisone treatments
□ Developmental disorders
□ Diabetes
□ Drug / Alcohol use
□ Epilepsy
□ Fainting
□ Food allergies ___________
□ Glaucoma
□ Headaches
□ Hearing Impaired
□ Heart problems __________
□ Hemophilia
□ Hepatitis
□ Herpes
□ High Blood Pressure
□ Jaw pain
□ Kidney disease / dialysis
□ Liver disease
□ Material allergy (latex, wool, metal, chemicals)
□ Intellectual Disability
□ Mitral Valve Prolapse
□ Pacemaker
□ Physical handicaps
□ Psychiatric care
□ Radiation TX
□ Respiratory
□ Rheumatic Fever
□ Scarlet Fever
□ Sickle Cell Anemia / Trait
□ Skin rash
□ Special Needs Patients ___________
□ Stroke
□ Surgical implant
□ Swollen feet / ankles
□ TB / or persistent cough
□ Thyroid disease
□ Tobacco habit
□ Tonsillitis
□ Ulcer
□ Venereal disease

Please list any health problems not listed above:
____
____

List any medications you are currently taking on a routine basis:
____

List any drug allergies, if any:
____

Doctors Notes: ____
____

I understand the above information is necessary to provide me / my child with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency to release such information to you. I will notify the doctor of any changes in my / my child's health or medication. I authorize release of any records or information to coordinate my / my child's healthcare with other medical professionals.

I agree to be responsible for this account and arrive on time for scheduled appointments. Appointments are the responsibility of the patient. Our practice provides courtesy calls 2 business days in advance of your scheduled appointment. I understand changes or cancellations of mine or my child's appointment require 2 days business notice. A fee of $75 per 60 mins of my scheduled appointment will be charged as a broken appointment fee. A fee of $150 per 60 mins of my scheduled appointment will be charged as a broken appointment fee for SURGERY appointments WITHOUT 48 hour business notice. No charge will be made for rescheduling an appointment, provided **48 business hours** notice is given.

I agree to be responsible for **all charges,** including those not covered by my insurance company. I understand that payment is due at the time of service. We accept cash, personal checks, Visa, MasterCard, Discover and Care Credit (healthcare financing). There will be an 18% APR added to any account 60 days or more past due irregardless of insurance coverage. A $30 bank fee is accrued on accounts for returned checks. In the unlikely event that my account is placed for overdue collections, I understand that I must pay all costs and expenses incurring on my behalf for the full collection of the account. When applicable, delinquent accounts are reported to the Credit Bureau.

I also acknowledge receipt of Stonewall Dental Associates' **Notice.**

****Patient/Guardian Signature***____ ***Date***______________________________

Doctor Signature ____ ***Date*** ____________________________