



## PATIENT INFORMATION

Patient Name \_\_\_\_\_  Male  Female  
Address \_\_\_\_\_ Apt \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Mobile \_\_\_\_\_  
E-Mail \_\_\_\_\_ Work Phone \_\_\_\_\_  
How do you prefer to be contacted? \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
How did you hear about our office? \_\_\_\_\_

## FINANCIAL POLICY

Payment of services is due at the time services are rendered. We accept cash, check, and credit cards.

**All checks will be processed electronically.** There will be a \$30 fee charged for returned checks if we are unable to process electronically.

Your insurance policy is a contract between you, your employer and the insurance company. We are **not** a party to that contract. Our involvement will be limited to supplying factual information to facilitate claim processing. All charges are your responsibility whether your insurance company pays or does not pay.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Fees for these services, along with unpaid deductibles and co-payments, are due at the time of treatment.

If your insurance company does not pay your claim in 30 days, it is your responsibility to contact your insurer to expedite payment. **If your insurance does not pay, you are responsible for your payment.** If your insurance company does not pay in full within 45 days, we require you to pay the balance. Balances older than 60 days may be subject to collection placement and fees.

A. I authorize payment from my insurance carrier be made directly to Dr. Alicia R. Gray/ Dr. Fatima Robertson.

B. I authorize this office to release necessary medical and/or dental information.

Thank you for choosing this office for your endodontic/periodontal treatment. We appreciate your trust in us and the opportunity to serve you.

**Patient or Guardian Signature**

**Today's Date**

\_\_\_\_\_

\_\_\_\_\_

# PATIENT MEDICAL HISTORY

## CONFIDENTIAL

Check (x) if you have had problems with any of the following:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad breath              | <input type="checkbox"/> Grinding teeth                 | <input type="checkbox"/> Periodontal treatment          |
| <input type="checkbox"/> Bleeding gums           | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sores or growths in your mouth |
| <input type="checkbox"/> Sensitivity to hot/cold | <input type="checkbox"/> Sensitivity to sweets          | <input type="checkbox"/> Sensitivity when biting        |

### MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Have you had any serious illnesses or operations? \_\_\_\_\_ If yes, describe \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.)  Yes  No

(Women) Are you pregnant?  Yes  No      Nursing?  Yes  No      Taking birth control pills?  Yes  No

**Are you taking (or have taken) any oral or IV bisphosphonates (Fosamax, Boniva, Actonel, Aredia, Zometa, etc.)?**  Yes  No

Check ( ) if you have or have had any of the following:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cough up Blood      | <input type="checkbox"/> HIV/AIDS  |   |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Jaw Pain  | <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Kidney Disease                                  | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Liver Disease                                   | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Food Allergies      | <input type="checkbox"/> Material allergies(latex,wool, metal,chemicals) | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Mitral Valve Prolapse                           | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Nervous Problems                                | <input type="checkbox"/> Surgical Implant           |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Pacemaker/Heart Surgery                         | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart Problems      | <input type="checkbox"/> Psychiatric Care                                | <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Hemophilia          | <input type="checkbox"/> Rapid Weight Gain or Loss                       | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Radiation Treatment                             | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Cortisone Treatment     | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Respiratory Disease                             | <input type="checkbox"/> Ulcer/Colitis              |
| <input type="checkbox"/> Cough, Persistent       | <input type="checkbox"/> High Blood Pressure |  |   |

### MEDICATIONS

List medications you are currently taking: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Doctor's comments \_\_\_\_\_

\_\_\_\_\_

### SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform Dr. Alicia Gray and/or Dr. Fatima Robertson, if I, or my minor child, ever have a change in health.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient



## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

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### For Office Use Only

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) \_\_\_\_\_