Legacy Smiles Family Dental

"Your Smile is Our Legacy"

John D. McMurray, DDS — Brad J. Williams, DDS

Patient Information

Today's Date: _____ E-mail Address: _____

Name: _____ ❑ Male ❑ Female _____
Last First Mi Mr Mrs Ms Dr **The Name I prefer to be called**

Birth date: ___/___/___ Age: _____ Social Security #: _____ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Address: _____
Street City State Zip

Home Phone #: (___) _____ Cel/Other #: (___) _____ Work Phone #: (___) _____ Ext: _____

Employer: _____ How long there? _____ Occupation: _____

Address: _____
Street City State Zip

Other family members seen by us: _____

Whom may we thank for referring you? _____

Person responsible for account other than yourself

His/Her Name: _____ Relation: _____ Home Phone #: (___) _____

Employer: _____ Work Phone #: (___) _____ Ext: _____

Billing Address: _____
Street City State Zip

Spouse Information

His/Her Name: _____ Birth date: ___/___/___ Social Security #: _____

Employer: _____ Work Phone #: (___) _____ Ext: _____

Dental Insurance Information

Primary Insurance

Insurance Co. Name: _____ Phone #: (___) _____ Group #: _____ ID #: _____

Address: _____
Street/PO Box City State Zip

Policy Holder's Name: _____ Birth date: ___/___/___ Social Security #: _____ Relation: _____

Employer: _____ Address: _____
Street/PO Box City State Zip

Secondary Insurance

Insurance Co. Name: _____ Phone #: (___) _____ Group #: _____ ID #: _____

Address: _____
Street/PO Box City State Zip

Policy Holder's Name: _____ Birth date: ___/___/___ Social Security #: _____ Relation: _____

Employer: _____ Address: _____
Street/PO Box City State Zip

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you maintain and reach maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Medical History

Name of primary physician: _____

Have you ever been hospitalized or had a major operation? ❑ Yes ❑ No ❑ N/A _____

Have you ever had a serious head or neck injury? ❑ Yes ❑ No ❑ N/A _____

List medications, pills, or drugs you are currently taking? _____

Do you take or have you ever taken Phen-Fen, or Redux? ❑ Yes ❑ No ❑ N/A _____

Do you take Fosamax, Boniva, Actonel or any other medication containing bisphosphonates? ❑ Yes ❑ No ❑ N/A _____

Are you on a special diet? ❑ Yes ❑ No ❑ N/A _____

Do you use tobacco? ❑ Yes ❑ No ❑ N/A _____

Do you use controlled substances? ❑ Yes ❑ No ❑ N/A _____

Wom en: Are you Pregnant? ❑ Yes ❑ No Due Date_____ Trying to get pregnant? ❑ Yes ❑ No

Nursing? ❑ Yes ❑ No Taking oral contraceptives? ❑ Yes ❑ No

Are you allergic to any of the following:

Aspirin ❑ Yes ❑ No Penicillin ❑ Yes ❑ No Codeine ❑ Yes ❑ No Acrylic ❑ Yes ❑ No Metal ❑ Yes ❑ No

Latex ❑ Yes ❑ No Local Anesthetics ❑ Yes ❑ No Sulfa drugs ❑ Yes ❑ No Other ❑ Yes ❑ No _____

Have you experienced the following:

Aids/HIV Positive ❑ Yes ❑ No	Diabetes ❑ Yes ❑ No	Hepatitis B or C ❑ Yes ❑ No	Renal Dialysis ❑ Yes ❑ No
Alzheimer's Disease ❑ Yes ❑ No	Drug Addiction ❑ Yes ❑ No	Herpes ❑ Yes ❑ No	Rheumatic Fever* ❑ Yes ❑ No
Anaphylaxis ❑ Yes ❑ No	Easily Winded ❑ Yes ❑ No	High Blood Pressure ❑ Yes ❑ No	Rheumatism ❑ Yes ❑ No
Anemia ❑ Yes ❑ No	Emphysema ❑ Yes ❑ No	High Cholesterol ❑ Yes ❑ No	Scarlet Fever ❑ Yes ❑ No
Angina ❑ Yes ❑ No	Epilepsy or Seizures ❑ Yes ❑ No	Hives or Rash ❑ Yes ❑ No	Shingles ❑ Yes ❑ No
Arthritis-Gout ❑ Yes ❑ No	Excessive Bleeding ❑ Yes ❑ No	Hypoglycemia ❑ Yes ❑ No	Sickle Cell Disease ❑ Yes ❑ No
Artificial Heart Valve* ❑ Yes ❑ No	Excessive Thirst ❑ Yes ❑ No	Irregular Heartbeat ❑ Yes ❑ No	Sinus Trouble ❑ Yes ❑ No
Artificial Joint* ❑ Yes ❑ No	Fainting Spells/Dizziness ❑ Yes ❑ No	Kidney Problems ❑ Yes ❑ No	Sleep Apnea ❑ Yes ❑ No
Asthma ❑ Yes ❑ No	Frequent Cough ❑ Yes ❑ No	Leukemia ❑ Yes ❑ No	Spina Bifida ❑ Yes ❑ No
Blood Disease ❑ Yes ❑ No	Frequent Diarrhea ❑ Yes ❑ No	Liver Disease ❑ Yes ❑ No	Stomach/Intestinal Disease ❑ Yes ❑ No
Blood Transfusion ❑ Yes ❑ No	Frequent Headaches ❑ Yes ❑ No	Low Blood Pressure ❑ Yes ❑ No	Stroke ❑ Yes ❑ No
Breathing Problem ❑ Yes ❑ No	Genital Herpes ❑ Yes ❑ No	Lung Disease ❑ Yes ❑ No	Swelling of Limbs ❑ Yes ❑ No
Bruise Easily ❑ Yes ❑ No	Glaucoma ❑ Yes ❑ No	Mitral Valve Prolapse* ❑ Yes ❑ No	Thyroid Disease ❑ Yes ❑ No
Cancer ❑ Yes ❑ No	Hay Fever ❑ Yes ❑ No	Osteoporosis ❑ Yes ❑ No	Tonsillitis ❑ Yes ❑ No
Chemotherapy ❑ Yes ❑ No	Heart Attack/Failure ❑ Yes ❑ No	Pain in Jaw Joints ❑ Yes ❑ No	Tuberculosis ❑ Yes ❑ No
Chest Pains ❑ Yes ❑ No	Heart Murmur* ❑ Yes ❑ No	Parathyroid Disease ❑ Yes ❑ No	Tumors or Growths ❑ Yes ❑ No
Cold Sores/Fever Blisters ❑ Yes ❑ No	Heart Pace Maker* ❑ Yes ❑ No	Psychiatric Care ❑ Yes ❑ No	Ulcers ❑ Yes ❑ No
Congenital Heart Disorder ❑ Yes ❑ No	Hemophilia ❑ Yes ❑ No	Radiation Treatments ❑ Yes ❑ No	Venereal Disease ❑ Yes ❑ No
Convulsions ❑ Yes ❑ No	Heart Trouble/Disease* ❑ Yes ❑ No	Recent Weight Loss ❑ Yes ❑ No	Yellow Jaundice ❑ Yes ❑ No
Cortisone Medicine ❑ Yes ❑ No	Hepatitis A ❑ Yes ❑ No		

Have you ever had any serious illness not listed above? ❑ Yes ❑ No ❑ N/A _____

Comments: _____

Dental History

Do you like your smile? ❑ Yes ❑ No _____

Are you currently in pain? ❑ Yes ❑ No _____

Do you require antibiotics before dental work? ❑ Yes ❑ No _____

Do your gums ever bleed? ❑ Yes ❑ No _____

Have you ever experienced pain/discomfort in your jaw joint? ❑ Yes ❑ No _____

I understand the information I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature of Patient, Parent or Guardian Date

LEGACY SMILES FAMILY DENTAL

FINANCIAL POLICY

This is an agreement between Legacy Smiles Family Dental and the patient. By executing this agreement, you are agreeing to pay for all services that are received.

Payments: Payment for service is expected at time of service unless we approve other arrangements in writing prior to your appointment. Accounts are considered past due if not paid by the 15th of each month.

Payment options:

A. You may pay your portion at time of service by Cash, Check, Visa, Master Card, Discover, American Express or Care Credit.
B. On extensive treatment (crowns, bridges, etc.) you may pay 50% of your portion on the preparation date, and the balance on the delivery date.

Finance Charge: A finance charge may be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one and one-half percent (1 ½%) per month or an **ANNUAL PERCENTAGE RATE** of eighteen (18%) percent. The minimum finance fee is $2.50.

Late Fee: A late fee of $25 may be assessed on all charges that are not paid in full by the 15th of each billing cycle.

Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your insurance company as a courtesy to you. Although we will estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree and understand that YOU are responsible for benefits, payments, or any claim inquiries including yearly maximums.

Returned Checks: There is a fee (currently $20) for any checks returned by the bank.

Missed Appointment Fee: We require at least 48-hour notice in order to change any appointments. There may be a $75.00 fee per hour of scheduled treatment time for all appointments that are missed or cancelled less than 48 hours in advance.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which are incurred plus all court costs. In case of suit, the venue shall be in Ada County.

Waiver of Confidentiality: If this account is referred to an attorney or collection agency or if we have to litigate in court, the fact that you received treatment in office will become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After the divorce or separation, the parent authorizing treatment for the child will be the parent responsible for those charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Checks: When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. For inquiries, please call 208-888-3311. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day you make your payment, and you will not receive your check back from your financial institution."

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

For Patients with Insurance: I hereby assign all dental benefits, to include major dental benefits to which I am entitled, including private insurance and any other health plans, to Brad J. Williams DDS and John McMurray, DDS.

Patient Name: _____.

Responsible Party Signature:_____, **Date:**_____.

Legacy Smiles Family Dental

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.

_____
{Signature}

_____
{Date}

For Office Use Only

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)

_____

_____

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