



## Welcome to Troy Family Dental!

We are excited to have you here in the practice as our patient.

To help us get acquainted, please answer a few short questions about yourself.

TODAY'S DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

EMAIL: \_\_\_\_\_

CELL/TEXT: \_\_\_\_\_

When was your last visit to a dentist? \_\_\_\_\_

Have you ever had to have a deep cleaning? \_\_\_\_\_

Have you ever been told you have to take antibiotics prior to seeing a dentist? \_\_\_\_\_

Do you currently have any pain or issues in your mouth that you are concerned with today?

\_\_\_\_\_

On a scale from 1 to 10 with 10 being highest how would you rate your dental health? \_\_\_\_\_

On the same scale how important is your dental health to you? \_\_\_\_\_

If you had a magic wand and could change anything about your smile what would it be?

\_\_\_\_\_

Who may we thank for your referral?

Facebook

Yelp

Google

Health Fair

Insurance Company

Location

Phone Book

Web Search

Friend/Family Member \_\_\_\_\_ Team Member \_\_\_\_\_



# TROY FAMILY DENTAL

## Financial Policy & Patient Agreement

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment. All patients must complete our Patient Information and Insurance form before being seen by the doctor.

**Please Note:**

- Payment Due At The Time Of Service
- We Accept Cash, Checks and Credit Cards (VISA, MasterCard, Discover & American Express)
- Financing available through CareCredit (Applications available)

**No Show/ Short Notice Cancellation Policy**

Your appointment time is important not only for you, but also to Dr. Troy and other patients who are in need of our services. **If you cannot keep your appointment for any reason, please call us within 48 business hours prior to your appointment time.** If you do not show for your appointment or cancel with less than 48 business hours' notice, a fee of \$50 will be charged to your account. You will be personally responsible for this charge. This charge will not be billed to nor paid for by your insurance company.

**Regarding Insurance**

We have accepted assignment of dental benefits. However, we do require payment of deductibles and any portion not paid by insurance by one of the options listed above. You are responsible for any remaining balance whether your insurance company pays or not. We cannot bill your insurance unless you give us complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid in full within 90 days, the balance becomes due and payable. Delinquent accounts will bear interest at a rate of 1% per month (12% annually) on the unpaid balance.

(Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney fees and collection expense. All delinquent accounts bear interest at legal rate.)

**Usual and Customary Rates / Maximum Allowable Benefit**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for treatment regardless of any insurance company's arbitrary determination of usual and customary or maximum allowable benefits.

**Minor Patients**

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment at the time of treatment or by one of the other options listed above.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

**No photography or videography without verbal permission**

**I have read the Financial Policy and Patient Agreement. I understand and agree to the Financial Policy and Patient Agreement.**

\_\_\_\_\_  
Patient Name (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Responsible Party

(Must be 18 or older)

\_\_\_\_\_  
Relation to Patient

# Troy Family Dental – JD Troy DDS, PLLC

Longview, Washington 98632

## Acknowledgment of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of JD Troy DDS, PLLC. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

JD Troy DDS, PLLC reserves the right to change the privacy practices that are currently described in the Statement of Privacy Practices. If the privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

### **ADDITIONAL DISCLOSURE AUTHORITY**

*In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)*

Spouse only \_\_\_ YES \_\_\_ NO

Any Member of my immediate family (Spouse, Children, Children's Spouses) \_\_\_ YES \_\_\_ NO

Any Member of my extended family: (Parents, Grandchildren) \_\_\_ YES \_\_\_ NO

Other:

**Name of Patient (please print):**

**Patients Signature (if 18 years old or older):**

**Patient's personal representative (please print):**

**Personal Representative's signature:**

**Representative's Telephone Number:**

**Date:**

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### **OFFICE USE BELOW THIS LINE**

#### **Acknowledgement not obtained**

Provided Prior to Treatment?  YES  NO Date Statement Provided: \_\_\_\_\_

Reason for Denial:  Needed More Time to review Statement of Privacy Practices

Wanted to Consult with another person before signing

Physically Unable to Sign

No Reason Offered

Other: \_\_\_\_\_

**MEDICAL HISTORY**

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No
- Do you use tobacco?  Yes  No
- Do you use controlled substances?  Yes  No

Women: Are you

Pregnant/Trying to get pregnant?  Nursing?

Taking oral contraceptives?

Are you allergic to any of the following? \_\_\_\_\_

Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  Sulfa Drugs

Other If yes, please explain: \_\_\_\_\_

- Do you have, or have you had, any of the following?
- |   |  |  |  |   |
|---|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive      | <input type="checkbox"/> Chest Pains               | <input type="checkbox"/> Frequent Headaches    | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Alzheimer's Disease    | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes        | <input type="checkbox"/> Irregular Heartbeat   | <input type="checkbox"/> Rheumatism                 |
| <input type="checkbox"/> Anaphylaxis            | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> Leukemia              | <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> Angina                 | <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Heart Attack/Failure  | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Sickle Cell Disease        |
| <input type="checkbox"/> Arthritis/Gout         | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Heart Pacemaker       | <input type="checkbox"/> Lung Disease          | <input type="checkbox"/> Spina Bifida               |
| <input type="checkbox"/> Artificial Joint       | <input type="checkbox"/> Easily Winded             | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Osteoporosis          | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Epilepsy or Seizures      | <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> Pain in Jaw Joints    | <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> Blood Transfusion      | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Hepatitis B or C      | <input type="checkbox"/> Parathyroid Disease   | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Breathing Problem      | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Bruise Easily          | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Radiation Treatments  | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Frequent Cough            | <input type="checkbox"/> High Cholesterol      | <input type="checkbox"/> Recent Weight Loss    | <input type="checkbox"/> Tumors or Growths          |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Frequent Diarrhea         | <input type="checkbox"/> Hives or Rash         | <input type="checkbox"/> Renal Dialysis        | <input type="checkbox"/> Ulcers                     |
|   |  |  |  | <input type="checkbox"/> Venereal Disease           |
|   |  |  |  | <input type="checkbox"/> Yellow Jaundice            |

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

\_\_\_\_\_

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_



\_\_\_\_\_  
*Previous Dentist/Dental Office*

\_\_\_\_\_  
*Mailing Address*

\_\_\_\_\_  
*City, State, Zip*

\_\_\_\_\_  
*Phone #*

\_\_\_\_\_  
*Fax #*

**Patient Name:** \_\_\_\_\_

**Patient Date of Birth:** \_\_\_\_\_

Please send the Following:

- Bitewing X-rays (If less than 1yr old)
- Pano/Full Mouth X-rays (If less than 5 years old)
- Periodontal Charting
- Dates of RPC (if applies) \_\_\_\_\_
- Last Date of Cleaning \_\_\_\_\_
- Treatment Findings
- Permission to send chart notes upon request

**I hereby authorize the release of dental records for the above-mentioned patient to:**

**Troy Family Dental  
JD Troy D.D.S., P.L.L.C  
1118 Ocean Beach Hwy.  
Longview, WA**

**Email: [frontdesk@troyfamilydental.net](mailto:frontdesk@troyfamilydental.net)**

**Your Name:** \_\_\_\_\_ **Relation to Patient:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Authorization Expires 90 days from date signature is acquired.*