North Royalton
FAMILY DENTAL
Nathaniel M. Taylor, DMD

PATIENT MEDICAL HISTORY

PAGE ONE

(CONFIDENTIAL INFORMATION FOR OUR FILES)

Last name: _____ First name: _____ MI:_____

Date of birth:_____ Driver's license number:_____

SSN: _____ Email address: _____

Home phone: _____ Cell: _____ Work Phone: _____

Address: _____ City: _____ State:_____ Zip:_____

Your employer: _____ May we contact you at work? .....❍ Yes ❍ No

HOW DID YOU HEAR ABOUT NORTH ROYALTON FAMILY DENTAL? ❍ Drive by ❍ Internet ❍ Direct Mail ❍ Insurance Plan
❍ Friend/Family ❍ Other | Referring patient name:_____

Spouse's name: _____ Employer:_____

Spouse's work phone: _____ Cell: _____ Number of dependents: _____

Person financially responsible for dependents: _____

IN CASE OF EMERGENCY, CONTACT: _____ Phone:_____

Previous Dentist (name/address/phone):_____

Do you have any current x-rays at your previous office? .....❍ Yes ❍ No

If yes, may we contact them to request copies be sent to us?.....❍ Yes ❍ No

Primary Insurance Information

Primary dental insurance company, including address: _____

_____

Name of insured: _____

Group name/number:_____

Insured date of birth: _____

SSN of insured:_____

Employer:_____

Employer address:_____

Employer city, state, zip _____

Secondary Insurance Information (if applicable)

Secondary dental insurance company, including address: _____

_____

Name of insured: _____

Group name/number:_____

Insured date of birth: _____

SSN of insured:_____

COMMENTS: _____

_____

_____

I authorize my insurance benefits to be paid to North Royalton Family Dental. I understand that ultimately I am financially responsible for all services I receive including co-pays, deductibles and non-covered services. Payment is expected at time of treatment unless other arrangements have been made with the billing department. I understand that my account will be assessed a monthly finance charge if my balance is carried longer than 30 days. I understand there will be a $35 fee for insufficient checks. If I fail to give 48 hours advance notice, I may be assessed a no-show fee equal to the value of the appointment I missed.

Signed: _____ Date:_____

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Patient's name: _____ **Date of birth:**_____

Are you under a physician's care now?.....❍ Yes ❍ No
If yes, please explain: _____

Physician's name:_____ Physician's phone: _____

Are you taking any medications, pills, or drugs? .....❍ Yes ❍ No
If yes, please list name and dosage: _____

_____

Have you ever taken medication for Osteoporosis?.....❍ Yes ❍ No

Do you take aspirin daily?.....❍ Yes ❍ No Quantity? _____ How often? _____

Have you been hospitalized in the past five years?.....❍ Yes ❍ No If yes, for? _____

Were you born with a heart condition?.....❍ Yes ❍ No If yes, explain? _____

Do you have an artificial heart valve? .....❍ Yes ❍ No

Have you ever had Infective Endocarditis? .....❍ Yes ❍ No

Do you have a prosthesis (for example: a knee or hip replacement)? ❍ Yes ❍ No
Please specify type and date of your prosthesis _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

❍ Aspirin ❍ Penicillin ❍ Codeine ❍ Acrylic ❍ Metal ❍ Latex
❍ Local Anesthetics ❍ Other (please explain):_____
_____

FOR WOMEN ONLY

Are you pregnant?.....❍ Yes ❍ No
If yes, what is your due date?_____
_____

Do you have a personal history of any of the following? Please check Yes or No.

Hemophilia (Bleeding)	❍ Yes ❍ No	Kidney or Liver Problems	❍ Yes ❍ No	A.I.D.S.	❍ Yes ❍ No	Arthritis	❍ Yes ❍ No
Heart Surgery or Disease	❍ Yes ❍ No	Blood Disease	❍ Yes ❍ No	H.I.V. Positive	❍ Yes ❍ No	Epilepsy	❍ Yes ❍ No
High Blood Pressure	❍ Yes ❍ No	Thyroid Trouble	❍ Yes ❍ No	Sinus Trouble	❍ Yes ❍ No		
Diabetes	❍ Yes ❍ No	Tumors	❍ Yes ❍ No	Psychiatric Care	❍ Yes ❍ No	Special Needs/Other	❍ Yes ❍ No
Rheumatic Fever	❍ Yes ❍ No	Cancer	❍ Yes ❍ No	Fainting Spells	❍ Yes ❍ No	_____	
Asthma	❍ Yes ❍ No	Radiation/Chemotherapy	❍ Yes ❍ No	Anemia	❍ Yes ❍ No	_____	
Ulcers/Gastro Problems	❍ Yes ❍ No	Hepatitis A	❍ Yes ❍ No	Hemophilia	❍ Yes ❍ No	_____	
Tuberculosis	❍ Yes ❍ No	Hepatitis B or C	❍ Yes ❍ No	Eye or Ear Problems	❍ Yes ❍ No		

Signed: _____ **Date:**_____

| 440.628.4458 | 6391 Royalton Road | Suite A | North Royalton, Ohio 44133

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INSURANCE PLANS AND FINANCIAL OPTIONS

(CONFIDENTIAL INFORMATION FOR OUR FILES)

Thank you for choosing North Royalton Family Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

| PAYMENT OPTIONS & INSURANCE PLANS WE ACCEPT |

We accept Cash, Check, Visa, Mastercard or Discover Card

Dental treatment should fit into your budget without you having to sacrifice the quality of dental care.

Or, you may choose NO INTEREST[1] Payment Plans[2] from CareCredit

Allows you to pay over time with NO INTEREST[1] | Convenient, low monthly payment plans[2] also available

No annual fees or pre-payment penalties | Pays for deductibles and treatments not covered by insurance

We are in-network with most dental insurance plans.

Careington | Cigna | Delta Dental DPO | Delta Dental Premier | DHA / Assurant | Humana

Maverest | Metlife | Principal | Superior Dental Care | Unicare

We are continuously updating the insurance plans we accept. If you don't see your plan listed, please ask if we accept it.

Please note:

- For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. However, you are ultimately responsible for all charges and what insurance does not cover.[3]

- We reserve the right to charge a fee, up to the value of the appointment, for patients who miss or cancel more than one time in a calendar year without 48-hour notice.

- North Royalton Family Dental requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

- North Royalton Family Dental charges $35 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature: _____ Date:_____

Patient Name (Please Print) _____

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required. [2]Subject to credit approval
[3]However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

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