Phone: 530.547.5757 *William L. Farrell DDS, F.A.G.D.* *9461 Deschutes Rd, Suite 2*
Fax: 530.547.5755 *Palo Cedro, CA 96073*

Welcome

We are pleased to welcome you to our practice!

Patient Information

Patient's last:_____First:_____M.I.:_____Date: _____

Social Security #_____Birth Date:_____Sex:_____Family Status: Single Married Divorced Child Other

Preferred appointment times (please circle): Morning Afternoon Evening Anytime / Days (please circle): Mon Tues Wed Thurs Fri Sat

How do you prefer to be contacted: Phone: Yes No / Email: Yes No / Text Messaging: Yes No

Home Phone:_____ Work:_____Cell:_____Other:_____

Physical Address:_____ Apt #_____City:_____State:_____Zip:_____

Mailing Address (PO Box, etc.): _____ City:_____State:_____Zip:_____

Email Address:_____

Emergency Contact: Name:_____Phone:_____

Whom may we thank for referring you to our practice?_____

Dental and Medical History

Date of Last Dental Visit:_____

Why have you come to the dentist today?_____

_____

_____

Are you currently in pain? Y N

Have you experienced problems associated with any previous dental work? Y N

Do you now or have you ever experienced pain/ discomfort in your jaw (TMJ/TMD)? Y N

Your current dental health is: Good Fair Poor

Do you Brush Daily? Y N Floss Daily? Y N

Are you happy with the way your smile looks? Y N

Type of bristles on your brush: Hard Med Soft

Do you use anything in addition to your brush and floss? Y N
If yes, what?_____

_____

Do your gums bleed? Y N

Have you ever had periodontal disease?_____

Are your teeth sensitive to heat, cold, or anything else?_____

_____

Have you lost any teeth? Y N If yes, why?_____

_____

Do you still have your wisdom teeth? Y N

Do you need to ***PRE-MED*** before dental work? Y N

If not, what would you change?_____

_____

_____

Have you experienced the following dental problems?

Bad Breath	Y	N		Fignernail biting	Y	N		Mouth Breathing	Y	N	
Bleeding gums	Y	N		Food collection between teeth	Y	N		Mouth pain, brushing	Y	N	
Blisters on lips or mouth	Y	N		Chew on foreign objects	Y	N		Orthodontic treatment	Y	N	
Burning sensation on tongue	Y	N		Grinding teeth	Y	N		Pain around ear	Y	N	
Chew on one side of mouth	Y	N		Gums swollen or tender	Y	N		Sensitivity to cold	Y	N	
Cigarette, pipe, or cigar smoking	Y	N		Jaw pain or tiredness	Y	N		Sensitivity to heat	Y	N	
Clicking or popping of jaw	Y	N		Lip or cheek biting	Y	N		Sensitivity to sweets	Y	N	
Dry mouth	Y	N		Loose teeth/broken filings	Y	N		Sensitivity when biting	Y	N	
How often do you Floss your teeth?_____					How often do you Brush your teeth?_____						

Thank you for filling out this form completely. It will enable our office to be more effective in meeting your needs. If you have any questions at any time, please ask. We will be happy to help you.

Medical History

Do you have a personal physician? Y N

Physician's Name _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Date of Last Visit? _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Y N

If yes, please explain: _____

_____

For Women: Are you pregnant? Unsure Y N Week # _____

Are you taking birth control? Y N Are you nursing? Y N

Are you ***ALLERGIC*** *to* any of the following?

Aspirin	Codeine	Jewelry	Erythromycin
Barbiturates	Sulfa Drugs	Sedatives	Penicillin
Tetracycline	Dental Anesthetics	Latex	Other

Please list additional drugs that cause allergic reactions: _____

_____

_____

Have you ever been hospitalized or had a serious illness or operation? Y N

If yes, date and condition treated: _____

Do you smoke or use tobacco in any other forms? Y N

Are you taking any of the following?

Acetaminophen	Blood Pressure Medication	Nitroglycerin	Antibiotics	Cold Remedies	Recreational Drugs
Antihistamines	Digitalis/Heart	Medication	Steroids/Cortisone	Aspirin or Ibuprofen	Tranquilizers
Thyroid Medicine	Insulin/Diabetes Drugs	Bisphosphonates	Blood Thinners	Other _____	

Are you taking any prescriptions or over the counter drugs? Y N If yes, please list each one: _____

_____

Have you experienced the following?

Abnormal Bleeding	Y	N		Fainting Spells	Y	N		Pacemaker	Y	N
Alcohol Abuse	Y	N		Fever Blisters	Y	N		Persistent Cough	Y	N
Anemia	Y	N		Frequent Headaches	Y	N		Psychiatric Problems	Y	N
Arthritis	Y	N		Glaucoma	Y	N		Radiation Treatment	Y	N
Artificial Bones/Joints	Y	N		Hay Fever	Y	N		Rheumatic Fever	Y	N
Artificial Valves	Y	N		Heart Attack	Y	N		Scarlet Fever	Y	N
Asthma	Y	N		Heart Murmur	Y	N		Seizures	Y	N
Blood Transfusion	Y	N		Heart Surgery	Y	N		Severe Headaches	Y	N
Cancer	Y	N		Hemophilia	Y	N		Shingles	Y	N
Chemotherapy	Y	N		Hepatitis	Y	N		Sickle Cell Disease	Y	N
Chicken Pox	Y	N		Herpes/Fever Blisters	Y	N		Sinus Problems	Y	N
Colitis	Y	N		High Blood Pressure	Y	N		Steroid Therapy	Y	N
Congenital Heart Defect	Y	N		HIV+/AIDS	Y	N		Stroke	Y	N
Diabetes	Y	N		Hospitalized	Y	N		Thyroid Problems	Y	N
Difficulty Breathing	Y	N		Kidney Problems	Y	N		Tonsillitis	Y	N
Drug Abuse	Y	N		Liver Disease	Y	N		Tuberculosis (TB)	Y	N
Emphysema	Y	N		Low Blood Pressure	Y	N		Ulcers	Y	N
Epilepsy	Y	N		Mitral Valve Prolapse	Y	N		Venereal Disease	Y	N

Please List any serious medical condition(s) that you have experienced: _____

_____

*I understand the medical and dental history is necessary to provide me 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 health care provider or agency. I will notify Dr. William L. Farrell DDS, of any change in my health or medication prior to treatment.

_____ _____

Signature of Patient, Parent or Guardian **Date**

_____ _____

William L. Farrell DDS **Assistant**

I have verbally reviewed the Medical/Dental information above with the patient named herein. Initials _____ Date _____

Doctor's Comments: _____

_____

Payment Information

Responsible Party Information (if under 18)

Name:_____ Relation to Patient_____

Social Security #_____ Birth Date:_____

Home Phone: _____ Work:_____ Other:_____

Address:_____

City:_____ State:_____ Zip:_____

Employment Information

Employer Name:_____ Occupation:_____

Address:_____

City:_____ State:_____ Zip:_____ Phone:_____

Insurance Information

Primary-

Insurance Company:_____ ID#_____

Name of Insured:_____ Is Insured a Patient? Y N

Social Security #_____ Birth Date:_____

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

Secondary-

Insurance Company:_____ ID#_____

Name of Insured:_____ Is Insured a Patient? Y N

Social Security #_____ Birth Date:_____

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

Consent of Services

I authorize Dr. William L. Farrell to take radiographs, study models, photographs and/or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of my dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication or therapy that may be indicated, authorize and consent that the Doctor choose and employ such assistance as he deems necessary. I also understand that ***responsibility for payment for Dental Services provided by this office for me and/or my dependents is solely mine***; due and payable at the time of services are rendered. ***As a courtesy, you will bill my insurance.*** Financial arrangements may be made in advance, including billing for dental insurance. However, I acknowledge that I am responsible for payment for all services rendered.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he/she is personally responsible for payment. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examination.

In consideration for professional services, I agree to pay the full amount owed said services to William L. Farrell DDS, at the time services are rendered or within five (5) days of billing if credit shall be extended. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

_____ _____ _____

Signature of Patient, parent or guardian **Date** Relationship to patient

Scheduling & Consent of Disclosure

Scheduling your Next Appointment

We make every effort to schedule appointments for the convenience of our patients. We need your cooperation to ensure that everyone has an opportunity for timely treatment. Please keep the following in mind:

Early morning, late afternoon, appointments and Saturday (By appointment only) are in great demand in our office. We will be happy to schedule you for one of these times if one is available, but we ask that you please make every effort to keep the appointment. Last minute changes often prevent us from offering these popular times to other patients who have requested them.

We fully understand that there are times when illness or unexpected obligations cause patients to reschedule appointments. However, we ask that you honor your appointments whenever possible so that you can stay on schedule and derive the maximum benefit from your treatment.

Notice: We do not double/triple- book at this office and as a courtesy to other patients, we request that you notify us within 24 hours if you need to change your scheduled appointment. ***As of June 1, 2015: There will be a fee of $50.00 assessed if we do not receive a call to cancel an appointment. ALL Saturday Appointments: There will be a fee of $100.00 assessed if we do not receive a call to cancel an appointment. Failure to do so could result in termination of services.***

Thank you for choosing us for your dental care. If at any time you have any questions about any of our services, please feel free to call us.

(Signature)_____ **(Date)**_____

Consent of Disclosure (*For the usage and/or Disclosure of Protected Health Information)*

I hereby give consent to William L. Farrell DDS, and all health care providers furnishing care within the offices of William L. Farrell DDS, to use and disclose my protected health information for the purposes of treatment, payment, and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address at the bottom of this form. This may be delivered by person or by mail, but it will only be effective when we actually receive it. Your cancellation will not be effective to the extent that we have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of you protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information about the usage and disclosure of your protected health information. You have the right to review our Posted Privacy Policy before you sign this consent.

We reserve the right to amend the terms of our Posted Privacy Policy. You may obtain a copy of the current policy by contacting the Office Manager.

Patient Name (Please Print)_____

Signature of Patient_____ **Date**_____/_____/_____

If you are signing as the patient's representative:

Relationship_____

Address for cancelation: Your cancellation will be effective, upon receipt, at the following address:

William L. Farrell D.D.S., F.A.G.D. 9461 Deschutes Road, Suite 2 Palo Cedro, CA 96073

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.

(Print name)

(Signature)_____ **(Date)**_____

******* OFFICE USE ONLY BELOW ********* OFFICE USE ONLY BELOW ******** OFFICE USE ONLY BELOW *******

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 _____Communication barriers prohibited obtaining the acknowledgement

_____An emergency situation prevented us from obtaining acknowledgement

_____Other (Please Specify)_____