NORTON
FAMILY DENTAL

PREOPERATIVE MEDICAL EVALUATION

Name:	Birth Date:	Age:	Weight:	Height:
Emergency Contact:	Relationship:		Phone:	
Primary Physician:	Last Visit Date:		Phone:	
Specialist Physician(s):	Reason for Specialist:			

1.) Do you suffer or have you been treated for ANY of the following? (Check any that are applicable.)

Cardiovascular	☑	**Nervous System**	☑	**Respiratory**	☑	**Endocrine**	☑
CAD (angina, heart attack)		Seizures/Epilepsy		COPD		Thyroid Disorders	
Heart Failure (weak heart)		Depression or Panic Attacks		Emphysema		Diabetes Mellitus –HbA1c: _____	
High Blood Pressure		Psychosis or Mania		Chronic Bronchitis		Immune Disorder	
Low Blood Pressure		Multiple Sclerosis		Asthma		Pregnant (Due Date:)	
Arrhythmias (irregular beat)		Headaches/Migraine		Sinus/Hay Fever		Breast Feeding	
Congenital Heart Defect		Dementia		**Miscellaneous**		**Excretory**	
Valve Disease or Murmur		Physical/Mental Impaired		Cancer		Liver Disorder	
Artificial Heart Valve		Infections		Radiation/Chemotherapy		Kidney Disorder	
Stroke or TIA		Hepatitis		Joint Replacements		Bladder Disorder	
Bleeding Problems		HIV/AIDS		Organ Transplants		Ulcers or GERD	
Blood Cell Disorders		Tuberculosis		Inner Ear Surgery		Intestinal Problems	

2.) Please list ANY **SURGERIES** or medical conditions that are not listed in the table above:

3.) Emergency Department visit or an overnight Hospital stay in the past 5 years? **Y / N**
4.) Are you taking any bone/calcium medications (Fosamax, etc.) or Bisphosphonates? **Y / N**
5.) Do you have any allergy or reaction to pain medications, antibiotics or Ibuprofen? **Y / N**

6.) Have you EVER received IV/Conscious Sedation? **Y / N** General Anesthetic? **Y / N** Any Complications? **Y / N**
7.) Do you have a history of sleep disorders or apnea? **Y / N** Do you take any medications to help you sleep? **Y / N**
8.) Do you smoke? packs/day. _____ **Y / N** Do you drink alcohol? drinks/wk. _____ **Y / N**

9.) Do you have any blood work drawn regularly? **Y / N**
10.) Do you have trouble swallowing pills? **Y / N**
11.) Do you have a history of substance abuse? **Y / N**

12.) Circle ALL activities you are physically able to perform:
wash dishes **vacuuming** **mow/rake** **climb stairs** **swim** **run**

13.) Please list ALL allergies to medications, foods or any other substances:

14.) Please list ALL medications you are currently taking – including non-prescription and herbal products:

Please List on Next Page

MEDICATION LIST

Patient Name: _____ Date: _____

DRUG	DOSE (mg)	FREQ.	REASON FOR USE	ACTION/CLASS

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FINANCIAL ARRANGMENTS, YOUR DENTAL INSURANCE, OFFICE TERMS & PROCEDURES

We are committed to providing you with the best possible dental care. If you have dental or medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy. We will be happy to process your insurance claim form by submitting a claim for each of your dental visits. From time to time, insurance will return a claim for further explanations, at that time we will contact you to talk to your insurance and work out the problem. If the problem is not resolved in a timely manner then we will look to you for full payment of the claim.

Co-payments are due at the time that services are rendered. For your convenience this office accepts, cash, checks, MasterCard, Visa, and Discover.

Prior authorization from your insurance will be done ONLY if you request that we submit such an authorization.. Please note that because of the large number of insurance companies our **ESTIMATES ARE SUBJECT TO ERROR AND NOT AN ACTUAL AMOUNT, BUT AN APPROXIMATE AMOUNT OF YOUR TREATMENT COST.** If there is a discrepancy at the end of treatment we will either refund any overpayment, or bill you for the balance.

Returned checks will be subject to additional collection fees of **$25.00.** Balances older than 30 days will be subject to finance (interest) charges of 1 ½% per month (18% annualized). Because we consider your time as valuable and schedule appointments for your care only, we expect you to return the consideration. ***Therefore, a minimum fee of $25.00 per half hour will be levied for broken appointments and appointments cancelled without 24 hour notice.***

We must emphasize that your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract. Our fees are generally considered to fall within the acceptable range by most companies, and, therefore are covered up to the maximum allowance determined by each carrier. "U.C.R" is a term defined as the usual, customary and reasonable fees for a certain region. We consider our fees to be Usual, Customary, and Reasonable. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We are required by law to give you a copy of our privacy notice, by signing this form you are acknowledging that the privacy notice has been offered to you.

In signing this form I consent to the treatment of my child by a licensed dentist or hygienist of Norton Family Dental Group even in the event I am unable to be present at the schedule time of the appointment. Any unforeseen circumstance that may occur during this treatment, I request that it be remedied to the best judgement of the dentist involved.

Norton Family Dental strives to provide perfection and satisfaction, which is why we are happy to stand behind all our dental work. However, we also expect you to stand behind your commitment to maintaining good oral hygiene by having your teeth professionally cleaned by our hygienist every six month (plus or minus 15 days). We will stand behind our sealants, white and silver fillings, crowns and fixed bridges for a period of three years. Our pledge for endodontic therapy (root canals) is for a period of one year unless appropriate restoration (crowning of the tooth) is performed and then it will extend to three years. WE WILL NOT STAND BEHIND OUR WORK UNLESS YOU ARE SEEN IN OUR OFFICE FOR YOUR REGULAR SIX MONTH CHECKUPS.

I HAVE READ THE ABOVE AND AGREE TO THE TERMS OUTLINED

Signed_____**date**_____