Smile.®

Family Dental Care Associates
J. Michael Fuchs, D.D.S., Inc.

THANK YOU FOR YOUR CONFIDENCE IN OUR CARE.

ADULT PATIENT INFORMATION

NAME _____ DATE OF BIRTH_____ SOCIAL SECURITY #_____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME TEL # _____ WORK TEL # _____
REFERRAL SOURCE:
TV _____ RADIO _____ YELLOW PAGES _____ NEWSPAPER _____ INSURANCE PLAN _____ OTHER_____
EMPLOYER _____ OCCUPATION _____
NAME OF SPOUSE _____ SPOUSE EMPLOYER _____
SPOUSE OCCUPATION _____ WORK TEL # _____
IF YOUR METHOD OF PAYMENT IS BY CHECK OR CREDIT CARD PLEASE COMPLETE THE FOLLOWING:
DRIVERS LICENSE # _____ STATE_____ EXP. DATE _____
MAJOR CREDIT CARD: ❑ VISA ❑ MASTERCARD ❑ SEARS ❑ DISCOVER
CREDIT CARD NO. _____ EXPIRATION DATE _____
WHO MAY WE CONTACT IN CASE OF EMERGENCY?
NAME _____ EMERGENCY TEL. # _____

INSURANCE INFORMATION

DO YOU HAVE DENTAL INSURANCE COVERAGE? YES _____ NO _____

PRIMARY INSURANCE	SECONDARY INSURANCE
HOLDER _____	HOLDER _____
DATE OF BIRTH _____	DATE OF BIRTH _____
INS. CO. NAME _____	INS. CO. NAME _____
GROUP # _____ LOCAL #_____	GROUP # _____ LOCAL #_____
POLICY # _____	POLICY # _____
EMPLOYER _____	EMPLOYER _____
PHONE NO. _____	PHONE NO. _____

HEALTH HISTORY

HAVE THERE BEEN ANY PROBLEMS IN YOUR GENERAL HEALTH WITHIN THE PAST 5 YEARS? (YES / NO)
(SERIOUS ILLNESS, HOSPITALIZATION SURGERY)
DESCRIBE PROBLEM _____
DATE OF LAST MEDICAL CHECK UP _____ ARE YOU UNDER PHYSICIANS CARE NOW? (YES / NO)
IF SO, PLEASE INDICATE WHY? _____
WHAT TABLETS, PILLS, OR LIQUIDS DO YOU TAKE (THIS INCLUDES ASPIRIN, VITAMINS, OTC, ETC.?
_____

Mason Montgomery
12160 Montgomery Road
Cincinnati, Ohio 45249
513-697-4300

Eastgate Mall
4595 Eastgate Blvd.
Cincinnati, Ohio 45245
513-753-8700

Northgate Mall
9505 Colerain Avenue
Cincinnati, Ohio 45251
513-385-7750

Tri County Mall
300 East Kemper Road
Cincinnati, Ohio 45246
513-671-6161

Western Hills Plaza
6016 Glenway Avenue
Cincinnati. Ohio 45211
513-481-2600

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DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS:

(PLEASE PLACE "X" BY ALL THAT APPLY)

❑ Rheumatic Heart disease ❑ Heart trouble ❑ Heart attack ❑ High blood pressure ❑ Stroke ❑ Pain in chest ❑ Shortness of breath ❑ Swollen ankles ❑ Rheumatic fever ❑ Heart murmur	❑ Blood test with unusual results ❑ Abnormal bleeding ❑ Prolonged healing ❑ Bruise easily ❑ Persistent cough ❑ Anemia ❑ Fainting spells ❑ Seizures ❑ Diabetes ❑ Blood disorders	❑ Tuberculosis ❑ Joint replacement surgery ❑ Hepatitis ❑ Jaundice ❑ Liver diseases ❑ Venereal disease ❑ Kidney troubles **Women:** ❑ Pregnant? If yes, provide estimated due date _____	❑ Lung diseases ❑ Asthma ❑ Sores that did not heal within one week ❑ Acquired immune deficiency syndrome ❑ Cough up blood ❑ Arthritis ❑ Low blood pressure ❑ Radiation treatment	❑ Sensitive or allergic to: ❑ Penicillin ❑ Codeine ❑ Novacaine ❑ Aspirin ❑ Anesthetics ❑ Other drugs? _____ Do you have any other disease, condition or problem that our doctors should know about? Yes____ No_____

YOUR DENTAL INFORMATION

1. WHAT BRINGS YOU TO OUR OFFICE TODAY? _____
2. HOW LONG HAS IT BEEN SINCE YOU HAVE BEEN TO THE DENTIST?_____
3. WHAT WAS DONE AT THAT TIME?_____ WAS A FULL MOUTH X-RAY TAKEN? (YES / NO)
4. DO YOU HAVE ANY OF THE FOLLOWING: BLEEDING GUMS (Y / N) SENSITIVITY (Y / N)
   PAIN AND/OR SWELLING (Y / N) MISSING TEETH (Y / N)
5. DO YOU NOW HAVE / AND, IF SO, HOW LONG HAVE YOU HAD:
   DENTURES (Y / N) _____ CROWNS (Y / N) _____ BRIDGEWORK? (Y / N) _____
6. WOULD YOU BE INTERESTED IN HAVING A CONSULTATION REGARDING ***DENTAL IMPLANTS***? YES / NO

PATIENT CONSENT AND AGREEMENT

I hereby give my permission to the Dentist and Specialists of Family Dental Care Associates, J. Michael Fuchs, DDS, Inc. and their staff ("FDCA") to do all such things as they deem necessary to diagnose, treat and care for my dental needs.

I also give my permission to FDCA to furnish any insurance company obligated to me, or any welfare or relief organizations, or any political subdivision to which I have applied or may subsequently apply for aid, any and all information with respect to any illness or injury, medical history, consultation, treatment or copies of such with respect to me and my family.

I understand and agree that even if I have dental insurance, I am personally responsible for paying for all services provided to me by FDCA irrespective of whether my insurance company covers the service provided. Unless I have paid in full for all services provided to me at the time of service, I hereby authorize my insurance company to pay directly to FDCA the benefits which would otherwise be payable to me. I understand and agree that even if I have dental insurance, FDCA has the right to require me to pay for a portion of the dental services provided to me by FDCA at the time services are rendered. This portion may be referred to as an estimate co-pay or patient portion or deductible. I further understand that if the total monies paid to FDCA by me and my insurance company is less than the fees for services provided by FDCA, I am personally responsible for making up the difference. If the total monies paid to FDCA by me and my insurance company is greater than the fees for services provided by FDCA, the excess will be credited to my account and/or refunded to me or my insurance company. I further agree to pay for all legal and/or collection fees associated with the collection of any balance on this account(s).

I understand that is it my responsibility to verify with my dental insurance company that a particular Dentist or Specialist is a participating provider in my dental plan. FDCA will make a reasonable attempt to assist me in this process, but the selection will ultimately be my responsibility. I understand that my dental coverage may require me to pay a greater copay (patient portion) if I decide to have my treatment provided by a Dentist or Specialist who is not participating in my dental plan.

I understand and agree that all clinical notes and x-rays taken remain the property of FDCA. If I find it necessary to obtain a copy of my records, there will be a charge for that service which I agree to pay. I understand and agree that with dental services, as with any other treatments of the body, the results are not always expected, desired or successful and that no guarantees are or can be made as to the result of any dental treatment or series of treatments.

By signing this document, I hereby agree to allow FDCA to charge to my credit card (listed on the other side of this form or any other credit card which was used to pay for my treatment) any unpaid balance remaining on my account after 120 days from my last date of treatment.

I have read and understand both sides of this form and in signing below I indicate my agreement with same.

_____/_____/_____
Signature of Patient — Date — Person Financially Responsible for this Account

_____/_____/_____
If patient is a minor (under age 18) signature of the Patient's legal guardian — Date