Patient Information

Patient Name: _____ Preferred Name: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Birth Date: _____ Social Security#: _____

Phone (Home): _____ (Work): _____ (Pager/Cellular) _____

Driver's License # _____

Address _____
Street Apartment#

_____
City State Zip Code

Employer Name _____ Occupation _____

Health Information

Current Medications _____

Date Of Last Dental Visit _____ Reason for this visit _____

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV	☐ Excessive Bleeding	☐ Liver Disease	☐ Stroke
☐ Allergies _____	☐ Fainting	☐ Mental Disorders	☐ Tuberculosis
_____	☐ Glaucoma	☐ Nervous Disorders	☐ Tumors
☐ Anemia	☐ Growths	☐ Pacemaker	☐ Ulcers
☐ Arthritis	☐ Hay Fever	☐ Currently Pregnant?	☐ Venereal Disease
☐ Artificial Joints	☐ Head Injuries	Due Date: _____	☐ OTHER
☐ Asthma	☐ Heart Disease	☐ Radiation Treatment	_____
☐ Blood Disease	☐ Heart Murmur	☐ Respiratory Problems	_____
☐ Cancer	☐ Hepatitis	☐ Rheumatic Fever	
☐ Diabetes	☐ High Blood Pressure	☐ Rheumatism	
☐ Dizziness	☐ Jaundice	☐ Sinus Problems	
☐ Epilepsy	☐ Kidney Disease	☐ Stomach Problems	

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
  Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  Is yes, please explain: _____

Referral Information

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

To the best of my knowledge, all of the preceding answers and information provided are true and correct.
If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

_____ Date: _____
Dr. Signature

Responsible Party Information

The following is for the person responsible for payment if different from the patient:

Name:_____

Relationship to patient ☐ Spouse ☐ Parent ☐ Child ☐ Other

Social Security #_____ Birth Date_____

Phone (Home):_____(Work):_____Ext:_____Best time to call:_____

Address:_____

Street Apartment #

_____

City State Zip Code

Employer Name:_____ Occupation_____

Address:_____

Street City, State Zip Code Phone

Insurance Information

Primary

Is policy holder

Name of Policy Holder:_____ a patient? ☐ Yes ☐ No

Last First MI

Policy Holder's Birth Date: _____ID#_____Group #_____

Policy Holder's Address:_____

Street City State Zip Code

Policy Holder's Employer Name:_____

Address:_____

Street City State Zip Code

Patient's relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address:_____

_____

Secondary

Is policy holder

Name of Policy Holder:_____ a patient? ☐ Yes ☐ No

Last First MI

Policy Holder's Birth Date: _____ID#_____Group #_____

Policy Holder's Address:_____

Street City State Zip Code

Policy Holder's Employer Name:_____

Address_____

Street City State Zip Code

Patient's relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address:_____

Consent for Services

As a condition of your treatment in this office, financial arrangements must be made in advance and credit information obtained when necessary. The practice depends upon reimbursement from the patients for 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 preformed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. 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 patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I also certify that all the information I submitted in the Health Questionnaire Form I submitted is true and complete. In order to receive treatment, I contract that in the event of any difference or disagreement between the attending Dentist and me, I will give that Dentist an opportunity to resolve the problem. A service charge of 1 ½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 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 six months from the date of the patient examination. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to, by me in writing, within the time for payment thereof. I further agree that a waiver of any breech 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 understand that this office is compliant with the HIPAA Act of 1996 and by signing this consent I authorize and disclose my health information for the operations of this practice. I grant my permission to you or your assignee, to telephone me at home or at work to discuss matters related to this form.

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

_____Date:_____Relationship to Patient:_____

Signature of patient, parent or guardian

_____Date:_____Relationship to Patient:_____

Signature of guarantor of payment/responsible party

PAYMENT POLICY

We are pleased to offer our patients quality, state of the art dentistry. As a courtesy to the patient, we will bill the insurance for you. You are responsible for all charges incurred for your dental treatment. In order to maintain this type of service, we must insist upon the following payment guidelines:

PPO INSURANCE

We are a provider for many PPO plans. Members of these plans are required to pay their co-payment at the time services are rendered. Any unpaid balance is the responsibility of the patient.

PRIVATE INSURANCE

We work with all private insurance companies. We will estimate the patient's portion of fees according to the information given to us by your insurance company. This portion is due at the time services are rendered. Any unpaid balance, is the responsibility of the patient.

NO INSURANCE

Uninsured patients will be responsible for payments in full, at the time services are rendered.

FAILURE TO APPEAR

There is a $25.00 charge for all failed appointments without a 24-hour notice.

CHECK CHARGE

There is a $25 charge for all returned checks. We accept local checks with picture I.D., most credit cards, and cash.

We hope our policy is not an inconvenience to our patients. We do appreciate you choosing our office for your dental needs. Thanks again for your patronage.

AGREED X_____

Patient's Signature