Patient Information

Patient Name: _____ Date:_____
Last First MI

Email_____ Gender_____ Married/Single or Child_____

Social Security #: _____ Birth Date:_____

Home Phone#: _____ Cell#:_____

Patient's Employer:_____ Work#: _____ Ext:_____

Patient's Address:_____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit:_____

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

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pregnancy Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Snore/Sleep Apnea
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Other Med. Allergy __

Other:

- ☐ _____
- ☐ _____

- 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
  If yes, please explain:_____

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

Medications

Please list any medications you are currently taking:

_____
_____
_____
_____

Referral Information

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

Emergency Contact/HIPAA Approved Contact:

Name:_____Relation:_____Phone:_____

Person Responsible for payment (If different than patient)

Relationship to Patient: ☐ Parent or ☐ Guardian ☐ Male or ☐ Female ☐ Married or ☐ Single

Name: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employer Name:_____

Address: _____
Street City State Zip Code

Patient's Dental Insurance Information

Primary

Subscriber's Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian

Name of Subscriber: _____ D.O.B.:_____ SS#_____
Last First MI

Subscriber's Address: _____
Street City State Zip Code

Subscriber's Employer: _____

Address: _____
Street City State Zip Code

Is the Insurance through this Employer? Yes ___ No____

Name of Insurance Co.: _____ ID #: _____ Group #:_____

Insurance Claims Address: _____

Secondary

Subscriber's Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian

Name of Subscriber: _____ D.O.B.:_____ SS#_____
Last First MI

Subscriber's Address: _____
Street City State Zip Code

Subscriber's Employer: _____

Address: _____
Street City State Zip Code

Is the Insurance through this Employer?: Yes ___ No____

Name of Insurance Co.: _____ ID #: _____ Group #:_____

Insurance Claims Address: _____

Please also provide us with a copy of your Medical Insurance Card as some services can be billed to both Medical and Dental as a courtesy to you.

Consent for Services

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. We accept cash, checks, all major credit and debit cards, and CareCredit. We have financing available through CareCredit and have options for those who may not be able to obtain financing. Future appointments will not be scheduled as long as there is a balance on your account

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

This dental office cannot render services on the assumption that our charges will be paid by an insurance company. We may call to verify your insurance, but we **may not** have detailed policy information such as waiting periods, limitations, or special clauses. Please read your dental insurance policy carefully; it is your responsibility to be aware of your plan benefits, as well as its limitations. Services not covered by your insurance will be your responsibility. It is your responsibility to inform the office of changes in your insurance carrier and coverage.

Diagnostic/preventive services do apply to your yearly maximum, and will not be covered once the insurance maximum for the current benefit period has been met.

Out of Network Insurance Plans: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible to pay the difference between our fee and what your insurance company determines to be the ñusual and customaryò rate.

I understand that fees are estimates and are only valid for six months from the date of the patient examination. Treatment can be altered if your dental needs change. You will be notified of any changes to treatment and estimates. We recommend dental treatment based on necessity, not based on what your insurance company may or may not cover. Once we provide you with this information, it is then your decision to accept or deny treatment. You have a right to request a Pre-Determination from your insurance company; however, this may delay your treatment by several weeks while we wait for the insurance to respond.

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 as billed unless objected to, by me, in writing, within the time for payment thereof. 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 also understand the doctors may use any diagnostics without said patientôs personal information attached for educational purposes.

MISSED APPOINTMENTS/RETURNED CHECKS: Unless cancelled **48 hours** in advance, our policy is to charge $25 for missed appointments at our discretion. For sedation and periodontal treatment appointments there is a $50 charge. In the event a check comes back due to insufficient funds, a service charge of $30 will be assessed to the patient.

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 also received a copy of the Office Policy and Notice of HIPAA Privacy Practice.

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

Signature of Dentist _____Date _____

Date Updated: _____ Date Updated: _____ Date Updated: _____ Date Updated: _____

Annual consent update: Initials:_____ Date Updated _____ Initials: ____Date Updated _____

Initials: _____ Date Updated _____ Initials: _____ Date Updated: _____

Initials: _____ Date Updated : _____