Patient Information

Patient Name: ____ Date: ___________
First, Last, MI (Preferred Name)

Gender: ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other______

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): ____________ (Work): ____________ (Cell): ____________ (Other): __________

Primary personal email address: ______________________

Address: ____
Street Apt #

____
City State Zip Code

Personal Health Information

****Date of Last Dental Visit: ____________ Reason for this visit: ______________________**

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

- ☐ AIDS / HIV
- ☐ Allergies ___________
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints _____ Date: __________
- ☐ Asthma
- ☐ Bis-Phosphonates
- ☐ Blood Dyscrasia/Ds.
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes (Type I / II)
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma __________
- ☐ Grafts/Stents/Shunts
- ☐ Head Injuries Date: ___________
- ☐ Heart Attack / MI Date: ___________
- ☐ Heart Disease / Stent
- ☐ Heart Murmur
- ☐ Hepatitis ________
- ☐ High Blood Pressure
- ☐ Infective Endocarditis
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ MRSA / VRE
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy (currently) Due date:__________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Smoke/Tobacco Use
- ☐ Stomach Problems
- ☐ Stroke / TIA Date:___________
- ☐ Tuberculosis
- ☐ Tumors / Cancer
- ☐ Ulcers
- ☐ Venereal Disease

DRUG ALLERGIES:

- ☐ Codeine Allergy
- ☐ Latex Allergy
- ☐ Penicillin Allergy
- ☐ Sulfa Allergy
- ☐ Other ____________________ ____________________
- ☐ Current Medications ____________________ ____________________ ____________________ ____________________ ____________________

- Have you ever been told you need to **Pre-Medicate** ? ☐ Yes ☐ No
  If yes, please explain: ____
- 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 status or medical history, I will inform the doctor or hygienist at the next appointment without fail.

____ Date: __________
Signature of patient or parent / guardian

New Patient Referral Information

Whom may we thank for referring you to our practice? ☐Another patient (friend/relative) ☐ Internet/Web

☐ Dental Office ☐ Phone Directory ☐ Newspaper ☐ School ☐ Work ☐ Other ______________

Name the above specifically referring you to our practice: ______________________________

Emergency Contact Information

The following is for: ☐ the patient's spouse/parent ☐ the person responsible for payment ☐ emergency contact

Name: ____

Gender: ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other______

Phone (Home): ________________ (Work): ________________ext: ______ (Cell): ______________________

Email address: ____

Address: ____

Street Apartment #

____

City State Zip Code

Insured Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ____________________________________ Occupation: ______________________________

Address: ____

Street City, State Zip Code Phone

Insurance Benefit Information

Name of Beneficiary: ____

Last First MI

Beneficiary's Birth Date: ___________________ S.S. # _____________________

Group #: ______________________ID # ________________________________

Beneficiary's Address: ____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ___________________

Benefit Plan Name and Address: ____

____

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 its patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. **Additionally, appointments must be respected and all appointments canceled without 48 hours notice are subject to a <u>$50 cancellation charge</u>. Appointments greater than one hour would be an additional rate of <u>$50/hour</u>. Furthermore, failure of an appointment without notice is subject to a <u>$50 per hour</u> delinquency charge.** All emergency dental services or any dental services performed without previous financial arrangements must be paid for in cash at the time services are rendered.

Patients who have dental benefits understand that all dental services furnished are charged directly to the patient, and they are personally responsible for payment of all dental services. This office will help prepare the patient's benefit forms, or assist in making collections from carrier 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 your carrier. **<u>It is the insured's responsibility to understand their dental benefits and is responsible for all charges incurred, not covered by their individual plan.</u>** You will also be given a **Benefit & Financial Policy Agreement** to sign – please note more details on that agreement as well.

In consideration for your health, X-rays are a necessary part of providing you with comprehensive dental care. If recent prior x-rays are not brought to your appointment, legally new x-rays will have to be taken. Please note that many benefit companies have limitations on the number of panoramic, bitewings and full-series radiographs taken within a period of time. Therefore, if the x-rays taken at your dental visit are not covered by your insurance, you will be financially responsible for those charges. Furthermore, the ADA and state health authority both recommend that fluoride treatments be administered twice per year for patients of all ages. We will adhere to this standard on all patients ages 16 and younger. If this treatment is not covered by your benefit plan, you **will be held financially responsible for the charges.** *Many carriers render benefits based on the* ***least expensive alternative treatment*** *philosophy* that they self-create. For example, some benefits will only be paid for a silver/amalgam filling as they consider the composite/tooth colored fillings to be an unnecessary luxury. In accordance with their philosophy, they will unilaterally **downcode** the procedure which places more of the financial responsibility on you. Please note this and recognize there may be a cost difference between 1950s dental procedures and 21st century treatment.

A service charge of 1½% 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.

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.

Duly signed: In consideration for the professional services rendered to me or at my request, by the Doctor, I agree to pay the outlined value of said services to the Doctor, or his assignee, at the time services are rendered, or within five (5) days of billing if credit shall be extended. I agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition. Furthermore, I agree to pay all costs and fees associated if an alternative means of collections is required.

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 payment and agree to their content. I also fully understand and agree to the HIPPA disclosure and protection agreement.

____ Date: _____________ Relationship to Patient: ___________________

Signature of patient, parent or guardian

____ Date: _____________ Relationship to Patient: ____________________

Signature of guarantor of payment/responsible party