Patient Information

Patient Name: _____ Date:_____ Male / Female
Last First MI

__ Married __ Single __ Child Birth Date:____-____-_____ Social Security #: _____-_____-_____
M D Y

Address: _____ _____
Street Apartment #

_____ _____ _____
City State Zip Code

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

Responsible Party Information

The following is for the person responsible for payment: __ self __ spouse __ parent or guardian

Patient Name: _____ Date:_____
Last First MI

Birth Date:____-____-_____ Social Security #: _____-_____-_____
M D Y

Phone (Home): _____ (Work): _____Ext:_____ (Cell): _____

E-Mail:_____ Fax: _____

Address: _____ _____
Street Apartment #

_____ _____ _____
City State Zip Code

Driver's License # _____ State _____

Insurance Information

Insurance Plan Name _____ Insurance Telephone: _____

ID #: _____ Group #: _____ Policy Holder"s Birth Date: ____-____-_____
M D Y

Policy Holder's Employer : _____

Employer's Address:_____
Street City State Zip Code

Name of Policy Holder: _____ Is this person a patient at our office? Y or N
Last First MI

Insurance Company's Address: _____ _____ _____ _____
Street City State Zip Code

Policy Holder's Phone (Home):_____ (Work):_____(Cell):_____

Patient's relationship to policy holder: __ Self __ Spouse __ Child __ Other (specify)_____

Health Information

Previous Dentist: _____ Date of Last Dental Visit: _____

Reason for this visit: _____

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

- ☐ AIDS
- ☐ Allergies_____ _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ **Artificial Joints**
- ☐ **Artificial/Leaky Heart Valve**
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Cold Sores/Fever Blisters
- ☐ Contact Lenses
- ☐ Cortisone Medication
- ☐ Diabetes
- ☐ Diet: (Special/ Restricted)
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ H. I. V. Positive
- ☐ Head Injuries
- ☐ **Heart** (Attack, Disease, Surgery)
- ☐ **Heart Murmur**
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ **High Blood Pressure**
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Latex Sensitivity
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ **Mitral Valve Prolapse**
- ☐ Nervous Disorders
- ☐ **Pacemaker**
- ☐ Psychiatric/ Psychological Care
- ☐ **Pregnancy:** Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ **Rheumatic Fever**
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Smoke/Chew Tobacco
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Allergic/Adverse Reaction To Medication or Any Substance, Please specify: _____ _____
- ☐ Do you pre-medicate with antibiotics prior to dental visits? ___ Yes ___ No

• Have you ever taken any of the following osteoporosis medications: Zometa, Aredia, Fosamax or Actonel? ____ Yes ____No

• 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:_____

• Are you taking any medications? Purpose? Please list_____

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

_____ Date:_____

Signature of patient, parent or guardian

Cancellation of Appointments

I agree to keep all scheduled appointments unless I notify the office at least 48 hours prior to the appointment. <u>I understand that failure to keep a scheduled appointment may result in a missed appointment fee of $40 per hour scheduled</u>. If we are able to fill your appointment spot with less notice we will not charge you.

_____ Date:_____

Signature of patient, parent or guardian

Consent for Services and Financial Information and HIPAA Information

Consent:

I hereby authorize the Doctor and/or his staff to take x-rays, models, photographs and other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of my /my charge's dental needs. Upon such diagnosis, I authorize the Doctor to perform all recommended treatment mutually agreed upon by me, and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. I understand, acknowledge, and agree that photographs and images of me may be shown to other patients, potential patients and doctors for treatment and educational purposes. I further understand that my name or identifying information will be kept confidential.

Financial Information:

As a courtesy, this office will help prepare and submit your insurance forms, however I understand that any fees not covered by insurance are my final responsibility. By signing this form I authorize this office to submit insurance claims and to contact my insurance company on my behalf. In consideration for the professional services rendered to me or at my request, I agree to pay for all services regardless of insurance coverage.

I understand that any fee estimate provided by this office for my dental care is only extended for a period of ninety (90) days from the date of the patient examination.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment from the patients for the 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 performed. A service charge of 18% per year will be charged to my account on any unpaid balance not paid the day of service, unless previously written financial arrangements are made. I understand that payment plans are available to assist with payment. I understand that in order to be approved for any payment plan options that a credit report may be run. By signing this form I authorize a credit check to be administered if I am asking for credit to be extended to me.

I understand that in the event that I default in the payment of fees due to the Doctor, I will be responsible for all expenses incurred by the Doctor including, but not limited to attorney fees, collection expenses, discretionary costs and court costs associated with collecting outstanding fees. I also understand that negative payment information may be reported to credit agencies.

HIPAA Information:

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out: Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment); obtaining payment from third party payers (e.g. my insurance company); the day-to-day healthcare operations of your practice. I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care options, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

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.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party