PERSONAL INFORMATION: PLEASE PRINT

Ms Miss Mrs. Mr. Dr.

Name____ Date of Birth_____________________Age_________

(Last) (First) (Middle)

Address_______________________________________ S.S.#_______________________________________

City & Zip Code______________________________ Phone:(H)____________________________________

(W)____________________________________

(C)____________________________________

If minor Parents name____________________________

Emergancy Contact:_______________________________ Email:_______________________________________

Reason for today's visit? ____

DENTAL INSURANCE:

Primary Insurance Carrier______________________________ Name of Insured ________________________________

*S.S.#/I.D.#*_______________________________________ *Insured's Date of Birth* _____________________________

*Group#*____

*Employer of insured*______________________________

*Secondary*Insurance Carrier______________________________ Name of Insured ________________________________

*S.S.#/I.D.#*_______________________________________ *Insured's Date of Birth* _____________________________

*Group#*____

*Employer of insured*______________________________

AUTHORIZATION:

I will participate fully as a member of my healthcare team. I will make sound choices regarding my treatment plans based upon the information provided by my Dental healthcare professionals. I agree to communicate with my Dental healthcare professionals any time I feel my well-being is being compromised.

***Our Office requires p*ayment at the time of service**, as a courtesy our office will submit insurance claims on your behalf. We will help coordinate with your Insurance Company and to the best of our ability establish an estimate of what will be the out of pocket expense for your treatment. Any monetary amount discussed is only our best Estimate of what your insurance will pay. We will only know the exact amount after your insurance claim has been processed.

I understand that I **am financially responsible to *YOUR OFFICE NAME* for any charges incurred by the above named patient**, and promise to pay promptly, the amount of such charges, which are not paid by any insurance carrier for any reason. Failure to pay in a timely manner may result in application of service charges to my account, or make me financially responsible for charges incurred to collect my account, including court cost, attorney fees and up to 115% of my balance for collection fees.

I understand that a certain amount of time has been set aside for my appointments, if I am unable to keep an appointment; **I agree that I will give at least 48 Hours notice.** If in the event that I am unable to give 48 hours notice, I understand that to *YOUR OFFICE NAME reserves the right to charge a **missed appointment fee of up to $100.00** to cover all expenses incurred due to the missed appointment time.*

I authorize release of any information relating to this claim to 3rd party payers. I hereby authorize direct payment to *INSERT LOGO HERE* - of the insurance benefits otherwise payable to me .I am aware that this practice makes every effort to conform to ***HIPPA Privacy Regulations***, but that my health care information may be released in the course of coordination of treatment and obtaining payment, and health care operations. I have been given the opportunity to review, have a copy of the ***Notice of Privacy Practices***, and ask questions regarding these policies and agree to the release of my personal health information when necessary.

Signature: ____Date:_________________________

(Financially responsible person and/or insured's Signature)

PLEASE COMPLETE THE MEDICAL INFORMATION ON THE OTHER SIDE

MEDICAL / DENTAL HISTORY

Approximate date of last dental visit ______________________Date of last x-rays____

Previous Dentist_________________________________ Address_________ ____
Last Dental treatment____

Any conditions that apply to your past Dental treatments or Oral health (Circle all that apply)

Excessive Bleeding	Nervous during treatment	Jaw Joint Pain / TMJ Disorder
Gums bleed while Brushing	Bad dental Experience	Difficulty Chewing
Hot/cold sensitivity	Food catches between teeth	Recent toothache
Happy with your Smile	Sensitivity to sweets	Pain or Discomfort
Trouble with Flossing	Yellow or stains on teeth	Concern with Oral Cancer

Primary Care Provider ______________________________________Address____
Phone ___________________________________ What is the date of your last visit?__________________________

Are you taking any medications or drugs? If so, please list……………………………………………. Yes No
____

Are you allergic to any of the following Medications **(Circle all that apply)**

Asprin	Nitrous Oxide	Penicillin
Darvon	Erythromycin	Local Anesthetic
Codeine	Tetracycline	Novocaine or Xylocaine
Demerol	Valium	Sleeping Pills
Percodan	Scopolamine	Nembutal/Seconal
Please list any other -		

Have you ever had any of the following conditions? (**Circle all that apply)**

Heart Condition/Surgery	General Fatigue	Spinal Injuries
Pacemaker	Multiple Sclerosis	Joint Replacement
Circulatory Condition/Problems	Fibromyalgia	Shoulder injury
High blood pressure	Chronic Fatigue Syndrome	Knee injury
Blood Conditions	Lung disease	Arthritis
Anemia	Difficulty Breathing	Heart Murmur
Bleeding problem	Emphysema	Seizures
Stroke	Asthma	Steroid therapy
HIV / AIDS	Psychiatric/Emotional disorders	Cancer
Compromised immune system	Radiation/chemotherapy	Kidney disease
Hepatitis	Stress	Liver disease
Diabetes	Thyroid disease	Lymphatic Conditions
Headaches/Migraines	Ulcer	Tuberculoses

Are you taking blood-thinning medications, including aspirin, ibuprofen or coumadin? ……………… Yes No
Are you pregnant? (Women)……………………………………………………………………………. Yes No
Are you taking birth control pills? (Women)…………………………………………………………. Yes No
When was your last physical? ____
Is this visit a result of accident or injury using workman's comp?………………………………………... Yes No
Please list any other Medical or Dental Conditions not addressed:
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____
____

Signature____Date________________________
(If client is a minor, Parent or legal guardian signature)

FINANCIAL POLICY: PLEASE READ AND SIGN

- Payment is due in full at the time of service. We do accept check, cash, Visa, Mastercard. There will be a $45.00 charge for all returned checks.

- As a courtesy, we will be happy to file your insurance claims for you and ask you for the estimated co-pays, previous balances, deductibles and any treatment that is not covered by your insurance carrier. If we are unable to collect payment from your insurance carrier, after 90 days, the unpaid balance will be billed to your account and you will pay your balance and collect the amount from your insurance directly.

- Broken appointments and canceling at the last minute are a burden. We ask that you notify us with a minimum 48-hour notice so we can schedule other patients.

- Note that with some procedures and/or in certain circumstances, partial payment or payment in full may be required in advance. We will advise you if applicable.

- We also have available dental finance plans from third party financial institutions. We do not offer in-house financing. **However**, we encourage you to consider some of the advantages of outside plans, including several no-interest options for qualified applicants.

- Accounts with balances older than 30 days may incur finance charges.

- Insurance companies may arbitrarily select what services they will cover even when an approved predetermination has been completed. When we verify benefits, your carrier will give us the general provisions of your coverage plan along with ***estimated*** benefits amounts. Actual claims may vary, so we will not know the exact dollar amount until the claim is paid.

- We will do our best to help you understand your dental insurance. However these kinds of questions are often best answered by your insurance carrier. It is your responsibility to know your insurance benefits and limitations.

- We will add up to a $100.00 charge for missed or no show appointments.

Signature____Date____________________

(If client is a minor, Parent or legal guardian signature)

Receipts of Notice of Privacy Practices

I, ____, have been offered a copy of this office's Notice of Privacy Practices.

Signature____Date______________________
(If client is a minor, Parent or legal guardian signature)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other
  ____
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