Patient Information

Name:_____ Date:_____
Last First MI Preferred Name

Gender: Male Female Married Single Child Other_____

Mailing Address:_____ City_____ State_____ Zip_____

Phone (Home):_____ (Work):_____ Ext._____ (Cell)_____

Social Security #:_____ Birth Date:_____ E-mail:_____

Spouse or Responsible Party Information

Name:_____
Last First MI Preferred Name

Gender: Male Female Married Single Child Other_____

Mailing Address:_____

Phone (Home):_____ (Work):_____ Ext._____ (Cell)_____

Social Security #:_____ Birth Date:_____ E-mail:_____

Employment Information

The following is for: the patient the parent

Employer Name:_____ Phone:_____ Ext._____

Dental Insurance Information

Primary

Name of Insured:_____ Insured's Phone :_____
Last First MI

Insured's Address:_____

Insured's Birth Date:_____ Insured's SS#:_____ ID#:_____

Insured's Employer:_____ Group #:_____

Insurance Plan Name:_____ Insurance Plan Phone #:_____

Patient's Relationship to Insured: Self Spouse Child Other

Secondary

Name of Insured:_____ Insured's Phone :_____
Last First MI

Insured's Address:_____

Insured's Birth Date:_____ Insured's SS#:_____ ID#:_____

Insured's Employer:_____ Group #:_____

Insurance Plan Name:_____ Insurance Plan Phone #:_____

Patient's Relationship to Insured: Self Spouse Child Other

Referral Information

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

Friend Sign Radio Yellow Pages Newspaper

Health Information

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? □ Yes □ No

Within the past year, have there been any changes in your general health? □ Yes □ No

Your Primary Care Physician (name, address and phone number): _____

Please mark any of the following to indicate "Yes" in response to the question:

□ Have you ever had complications following dental treatment?
□ Are you currently under the care of a physician due to a specific condition?
□ Have you been hospitalized within the last 5 years due to a surgery of illness?
□ Do you use tobacco (smoking or chewing)?
□ Do you require the use of corrective lenses (contacts or glasses)?
□ Do you have any other chronic conditions or diseases that we should be aware of?
□ Have you ever been diagnosed with Osteoporosis (if yes, please list any medications prescribed)?
□ DO YOU HAVE ANY ARTIFICAL JOINTS OR HEART VALVES?
If any of the previous questions are marked, please explain: _____

_____

Are you pregnant or trying? □ Yes due date:_____ □ No

Are allergic to any medications? □ Yes list:_____ □ No

Are you taking any medication now? □ Yes □ No

Please list all prescription, non-prescription, vitamins (if you use a specific pharmacy please note as well):

_____

_____

Medical Alerts:

Please indicate if you have experienced any of the following:

□ AIDS
□ Anemia
□ Aspirin Allergy
□ Birth Control
□ Ceclor Allergy
□ Codeine Allergy
□ Demerol Allergy
□ Epilepsy
□ Flagyl Allergy
□ Heart Murmur
□ Hepatitis A
□ High Fear
□ Jaundice
□ Latex Allergy
□ Nervous Disorders
□ On Blood Thinners
□ Penicillin Allergy
□ PREMED
□ Rheumatic Fever
□ Sleep Apnea
□ Sulfa Allergy
□ Ulcers
□ Allergies
□ Arthritis
□ Asthma
□ Blood Disease
□ Cipro Allergy
□ COPD
□ Diabetes
□ Epinephrine Allergy
□ Glaucoma
□ Heart Surgery
□ Hepatitis B
□ High Gag Reflex
□ Keflex Allergy
□ Liver Disease
□ Nitrous Allergy
□ Osteoporosis
□ Phenergan Allergy
□ Radiation Treatment
□ Rheumatism
□ Stomach Problems
□ Thyroid Disease
□ Amoxicillin Allergy
□ Artificial Joints
□ Bactrim Allergy
□ Cancer
□ Clindamycin Allergy
□ Cortisone Allergy
□ Dizziness/Fainting
□ Erythromycin Allergy
□ Heart Disease
□ Hemophilia
□ High Blood Pressure
□ Ibuprofen Allergy
□ Kidney Disease
□ MVP
□ Novocain Allergy
□ Pacemaker
□ Pregnant/Nursing
□ Respiratory Problems
□ Sinus Problems
□ Stroke
□ Tumors

Do you have any other health issues or allergies?

_____

_____

_____

_____

When was your last visit to the dentist (including orthodontist or oral surgeon)? Please explain what was done and provide us with office information.

_____

_____

_____

Emergency Contact

Name:_____ Phone #:_____

Relationship to Patient:_____

Please list someone other than a spouse. Must be someone at a different address and phone number.

Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
* Obtain payment from third-party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received a complete copy of *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change the *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Consent for Services

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.

The undersigned hereby authorizes Doctor to take study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the above mentioned patient and further authorize and consent that Doctor choose and employ such assistance deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due payable at the time of service unless prior financial arrangements have been made. I further understand that a 1.75% finance charge (21% annually) will be added to any balances over 60 days. In the event of default, I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this account.

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

Patient/Parent Signature:_____ **Date:**_____ **Staff Initials:**_____

Financial Policy:

_____
Initials

We look forward to helping you with your dental care as we are concerned about your dental health. Please remember that your dental insurance is your responsibility. As a courtesy we will file your dental insurance to help supplement your appointment. Regardless of what we may estimate as your dental insurance payment, keep in mind that it is an estimate only, you are responsible for the total treatment fee. We can accept assignment of benefit payments from most insurance companies. This will reduce your immediate, out-of-pocket expenditures. The outlined estimate is based on limited information obtained from your insurance company. We allow 45 days for your insurance company to make a payment, AFTER THIS TIME, THE TOTAL BALANCE AND ANY INSURANCE INQUIRES BECOME YOUR RESPONSIBILITY.

Scheduling Policy:

_____
Initials

The total treatment fee is due to schedule any appointments for treatment. If you have insurance to help supplement your appointment, your full co-pay amount will be due to schedule any appointments for treatment. All financial arrangements are made through our Healthcare Financing Programs (for more information please see our brochures on our approved financing programs). The fees reviewed with you will only be honored for 90 days from the date listed, after that time, the fees are subject to adjustments.

Cancellation Policy:

_____
Initials

Our doctors and professional team reserve designated appointment times to better serve our patient family. We will be calling 1-2 days prior to your appointment to confirm your appointment time. It is extremely important that you call back to confirm your appointments. A change in your schedule not only affects your health, it also affects the schedule of many other people.

If we are unable to reach you to confirm your appointment, we will be forced to give your scheduled appointment to another patient.

As a courtesy please give at least a 48 hours' notice if you are unable to keep an appointment. If you are unable to give at least a 24 hours' notice to reschedule and/or cancel an appointment, we will require a deposit in order to schedule you for future appointments. This fee will be credited to your account upon arrival of your appointment or will be forfeited if appointment is cancelled less than 24 hours (1 business day) prior to scheduled appointment time.

_____ _____

Patient/Parent Signature **Date**