

**CONFIDENTIAL PATIENT INFORMATION (PLEASE PRINT)**

Name \_\_\_\_\_ Mr. Mrs. Ms. Miss Date \_\_\_\_\_  
Last First MI

Address \_\_\_\_\_ Unit # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone # ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone # ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Patient SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Business Phone # ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Referring Dentist \_\_\_\_\_

Dental Insurance \_\_\_\_\_ Plan \_\_\_\_\_

Insured's Name Last First MI

Insured's SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insured's Home Address \_\_\_\_\_ Home Phone # ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured's Employer \_\_\_\_\_ Employer's Phone # ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Secondary Dental Insurance \_\_\_\_\_

Under whose name? \_\_\_\_\_ ID# \_\_\_\_\_

Have you ever had the following? Please check all that apply.

- |  |   |
|--|---|
| <input type="checkbox"/> YES <input type="checkbox"/> NO AIDS/HIV                    | <input type="checkbox"/> YES <input type="checkbox"/> NO Herpes                             |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Arrhythmia                  | <input type="checkbox"/> YES <input type="checkbox"/> NO High Blood Pressure                |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Artificial Joint            | <input type="checkbox"/> YES <input type="checkbox"/> NO Kidney Disease                     |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Asthma/Respiratory Problems | <input type="checkbox"/> YES <input type="checkbox"/> NO Liver Disorder or Hepatitis        |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Bleeding Disorder           | <input type="checkbox"/> YES <input type="checkbox"/> NO Mitral Valve Prolapse/Heart Murmur |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Cancer                      | <input type="checkbox"/> YES <input type="checkbox"/> NO Pacemaker                          |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Chemical Dependency         | <input type="checkbox"/> YES <input type="checkbox"/> NO Psychiatric Treatment w/Medication |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Diabetes                    | <input type="checkbox"/> YES <input type="checkbox"/> NO Rheumatic Fever                    |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Heart Attack                | <input type="checkbox"/> YES <input type="checkbox"/> NO Seizures                           |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Heart Valve Replacement     | <input type="checkbox"/> YES <input type="checkbox"/> NO Stroke                             |

• LIST ALL MEDICATIONS YOU ARE PRESENTLY TAKING:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Have you ever had an allergic reaction to any drug or local anesthetic?  YES  NO
- Do you premedicate for dental appointments? .....  YES  NO
- Is your general health good? .....  YES  NO
- Are you under a physician's care now? .....  YES  NO
- Do you have any disease, condition or problem not listed? .....  YES  NO

OFFICE USE ONLY
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We realize that from time to time questions may arise about our payment policy. This notice is designed to reduce any confusion or misunderstanding.

**INSURANCE** - Your insurance may not pay for all of your dental care cost. All insurance policies include some 'non-covered services'. This does not mean that the service is not necessary-it just means the insurance carrier will not pay for it. Remember, the insurance policy is a contract *between you and the insurance company*, the dentist has no control over what they do or do not cover.

In order to bill your insurance company for your dental visit, you must provide- us with your current insurance card or specialty referral form. If you do not provide this information, please expect to pay in full at the time of the office visit for services rendered.

**BILLING** - We will bill your insurance company when your treatment is completed. If you have indemnity insurance, it is our policy to collect a minimum of 50% of our fee at the time of your visit. This amount is determined by the type of coverage you carry. If the insurance company fails to reimburse our office within a 60 day period, you will receive a statement with the amount due and payable immediately. In addition to co-pays or deductibles, you are responsible to pay denied or non-covered services as determined by the insurance company. If we are an out-of-network provider, the non-covered services and deductibles are usually higher. Your insurance company, not the dentist, sets these amounts.

**APPOINTMENTS** - A fee will be charged for missed or cancelled appointments without 24 hours prior notification. Once an appointment is made, please remember this time has been reserved for you. We are aware that appointments must occasionally be rescheduled. Please telephone to change an appointment time or date as soon as possible.

**COLLECTIONS** - I agree to the release of my medical information should my account be turned over to a collection agency for non-payment, for any reason. I further acknowledge that a 40% collection fee will be added to any outstanding balance turned over to a collection agency. In addition, the unpaid balance will be reported to all credit repositories within 45 days of receipt by the collection agency.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

(Parent or guardian, if patient is a minor)

Please realize that maintaining financial viability is the only way we are able to continue providing quality services. Your cooperation enables us to deliver the type of dental care that you deserve and expect.