Patient Information

Date: _____ ***Please verify all information and make necessary changes***

Patient Name: _____ Marital Status: ***S M D Child Other***

Birth Date: _____ **Social Security #:** _____

If child, Parent name: _____

Address: _____

_____

City *State* *Zip*

Preferred contact type (circle all that apply): ***Text*** ***Email*** ***Phone***

Email: _____

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

Patient Health Information

Primary Doctor:_____ Hospitalizations within the last year: _____

Circle any **allergies** you may have:

Latex Penicillin Codeine Sulfa Peanut Local Anesthetics

Other Allergies: _____

Do you take Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?

Yes / No If yes, which one: _____

Please list all other medications: _____

_____

Do you need or currently take a Premedication before dental services: Yes No

If yes, for what medical condition: _____

Mark all that apply:

- ☐ AIDS/HIV
- ☐ Alzheimer
- ☐ Artificial Joints
- ☐ Autoimmune Disease
- ☐ Blood Thinners
- ☐ Cancer
- ☐ Chemo/Radiation
  - Date of last treatment:_____
- ☐ Diabetes: # of Insulin units daily: _____
- ☐ Epilepsy/Seizures
- ☐ Heart Conditions
- ☐ Hepatitis A, B, or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Pacemaker
- ☐ Pregnant
  - Due date:_____

Please list any other health issues:_____

_____

Employment Information

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

Employer Name: _ Phone:_____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

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

Insured's Employer Name: _____

Insurance Plan Name:_____

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

Financial Policies

Payment for all services is due when treatment is rendered. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment. Your estimated out-of-pocket portion is required at the time of service unless prior arrangements have been made. We accept Cash, Check, Debit Cards, Visa, Mastercard, Discover, American Express and Care Credit.

Our office is committed to helping you maximize your insurance benefits. Because insurance policies vary, we can only estimate your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts. We recommend that all patients contact their insurance company to better understand their benefits and how claims will be processed. We will attempt to help you receive full insurance benefits; however, you are personally responsible for your account, and we encourage you to contact your insurance company if they have not paid within 30 days.

If the patient is a minor (18 years and younger), the parent or guardian is responsible for payment of the account, in accordance with the policies outlined herein.

Missed Appointments

Your scheduled appointment time has been reserved specifically for you. If you are unable to keep an appointment it is required that you notify our office (even after hours) at least 12 hours in advance. Two failures to notify us less than 12 hours before your appointment will require a deposit of $50 to reserve any future appointments. Deposits made will be used towards patient services on next visit.

Acknowledgement of Receipt of Notice of Privacy Practices

This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices, Financial Policies and Missed Appointment policies. A written copy is posted in our office waiting room and can be provided to you if requested.

I have read the above Financial Policy, Missed Appointment Policies and Notice of Privacy Practices and agree to their content.

_____ **Date**: _____ **Relationship to Patient**: _____

Signature of patient, parent or guardian