Responsible Party Information

The following is for: ☐ self ☐ spouse ☐ parent or guardian

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

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

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

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

Employer Name: _____ Occupation: _____

Address: _____

Street City, State Zip Code Phone

Insurance Information

Primary

Name of Policy Holder: _____ Is policy holder a patient? ☐ Yes ☐ No

Last First MI

Policy Holder's Birth Date: _____ ID #: _____ Group #: _____

Policy Holder's Address: _____

Street City State Zip Code

Policy Holder's Employer Name: _____

Address: _____

Street City State Zip Code

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

Insurance Plan Name and Address: _____

_____

Secondary

Name of Policy Holder: _____ Is policy holder a patient? ☐ Yes ☐ No

Last First MI

Policy Holder's Birth Date: _____ ID #: _____ Group #: _____

Policy Holder's Address: _____

Street City State Zip Code

Policy Holder's Employer Name: _____

Address: _____

Street City State Zip Code

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

Insurance Plan Name and Address: _____

Financial Policy

This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

We would be happy to preauthorize any dental treatment in advance to determine coverage eligibility and patient payment responsibility.

I hereby authorize my insurance carrier to pay directly to the within named dentist the dental benefits otherwise payable to me. As most insurance plans only pay a portion of the treatment, any portion NOT PAID or NOT COVERED by the insurance company is DUE and PAYABLE at the time of treatment unless other arrangements have been made.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

WE REQUEST 24 HOUR NOTICE FOR CANCELLATION. A FEE OF $50 IS CHARGED FOR PATIENTS WHO MISS OR CANCEL WITHOUT 24 HOUR NOTICE.

Medical Health History

Have you ever had any of the following medical issues? Please check those that apply.

- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Acid Reflux
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ Dry Mouth
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting/Dizziness
- ☐ Heart Attack/Stroke
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Herpes/Fever Blisters/HPV
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nerve Disorders
- ☐ Pacemaker
- ☐ Radiation/Chemotherapy
- ☐ Pregnancy/Trying due date_____
- ☐ Tuberculosis
- ☐ Tumors
- ☐ History of Fosamax (history of bisphoshonate)

List any medications you are currently taking _____

_____

Do you have any Allergies? _____

Do you take Aspirin daily? Yes ☐ No ☐ Are you taking a blood thinner? Yes ☐ No ☐

Are you under medical treatment at this time? Yes ☐ No ☐

Name of Physician _____ Phone: _____

Dental Health History

Have you had any of the following dental issues? Please check those that apply:

☐ Bleeding gums ☐ teeth grinding/clenching ☐ Mouth ulcers

☐ Sinus problems ☐ TMJ Disorder ☐ Reaction to local anesthetic

Reason for today's visit _____ Approx. date of last dental visit/cleaning _____

Do you chew tobacco? Yes ☐ No ☐ Smoke? Yes ☐ No ☐

To the best of my knowledge all of the preceding answers and information provided and true and correct. If I ever have a change in my health, it is my responsibility to inform the doctors at the next appointment.

_

Please Print Name

_ _____

Signature of patient, parent or guardian Date

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

Patients with dental insurance understand that our office will bill your insurance company, and if a provider with your insurance, adjust accordingly to the allowance of each procedure. Any balance that remains, must be paid in full. Our office accepts checks, cash, and all major credit cards. We also work with Care Credit to help pay for your dental expense.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, unless other indicated.

I grant my permission to you or your assignee, to telephone me to discuss this matter or my treatment.

_____ By checking this line, I understand the above information and agree with its content, and this will serve as my electronic signature for the Administration Form.

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (Including account information, appointment information and clinical information) to the secured dental software. Correspondence with other dental office, specialists will be sent through our secure email. I understand the dental practice will use all reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the software on my behalf.

_____ I have read the information above regarding the secure uploading of patient information. I grant the dental practice permission to securely upload my patient information. This will serve as my electronic signature.

Signature: _____

Relationship to the patient: _____

HIPPA Acknowledgement

I authorize this office to disclose or discuss my personal and/or dental information with the following persons:

Please enter name and relationship to the patient: _____

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked. A written appeal must be sent. Although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

_____ By checking this line, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPPA Disclosure Form.