

DENTAL ASSOCIATES, P.C.

Date: _____ Dentist you wish to see: _____

Patient Name: _____
Last First MI Preferred Name

Marital Status: Single Married Other Sex: Male Female

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Social Security Number: _____ Date of Birth: _____ Age: _____

E-Mail Address: _____

Spouse's Name (or Parent/Guardian): _____

Guarantor's Name: _____ Guarantor's Social Security Number: _____

Guarantor's Address: _____

Guarantor's Employer: _____ Work Phone #: _____

Please list family members who are patients at Dental Associates: _____

Whom may we thank for referring you? _____

FINANCIAL GUIDELINES

In an effort to keep dental fees down, while maintaining a high level of professional care, we have established the following plans of payment for the use of our patients:

1. Payment in full for each visit is due unless financial arrangements are made in advance. We accept the following debit/credit cards: VISA, Mastercard, Discover and AMEX.
2. We will gladly accept payments from dental insurance companies. Current insurance information must be provided at each visit. The patient (guarantor) will be asked to pay the portion not covered by insurance at the time of the visit. The patient (guarantor) is responsible for any unpaid insurance claim after 90 days from the date of service.
3. Returned checks will be assessed a \$25.00 fee.
4. Interest free financial arrangements may be made for 3 or 6 months for qualified applicants through a third party financial institution.
5. The adult accompanying a minor and the parent and/or guardian of the minor is responsible for full payment.

OVER →

OFFICE INSURANCE POLICIES

You are responsible for payment of your account even though you may have insurance. Your insurance contract is an agreement between *you and your insurance carrier*. In the event your insurance pays you directly, payment will be due at time of service. While we cannot negotiate a settlement of your claim with the insurance company, we will, within our limits, assist you. If you provide proper information, we will file with your insurance. Payments made directly to us by your insurance company will be applied to your account and any overpayment will be refunded.

Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of the insurance company's arbitrary determination of usual and customary rates. **PLEASE CHECK WITH YOUR INDIVIDUAL INSURANCE PLAN TO DETERMINE IF WE ARE A PARTICIPATING PROVIDER.**

We will file an initial claim with your insurance carrier. If you have a secondary insurance, a claim will be filed with that carrier also, provided we have the necessary information (i.e. primary explanation of benefits, if payments are made to you). If payment is not received from your insurance company within 90 days, please remit balance promptly.

AUTHORIZATION FOR SIGNATURE ON FILE, PAYMENT AND RELEASE OF INFORMATION

I hereby authorize the office of DENTAL ASSOCIATES, P.C. to affix my name to any and all claims or documents as related to any and all dental benefits due to my dependents and me.

I hereby authorize the payment of dental benefits directly to the office of DENTAL ASSOCIATES, P.C. I authorize release of any information relating to this claim.

This "Signature on File" will be valid from this date and shall expire in one year.

Is the patient a FULL time college student? Name of College: _____ Hours Enrolled _____

PRIMARY DENTAL INSURANCE

SECONDARY DENTAL INSURANCE

Policyholder's Name: _____ Policyholder's Birthdate: _____ Policyholder's ID #: _____ Policyholder's SSN: _____ Policyholder's Group #: _____ Policyholder's Employer: _____ Insurance Company: _____ Policyholder's Signature: _____	Policyholder's Name: _____ Policyholder's Birthdate: _____ Policyholder's ID #: _____ Policyholder's SSN: _____ Policyholder's Group #: _____ Policyholder's Employer: _____ Insurance Company: _____ Policyholder's Signature: _____
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I HAVE READ AND UNDERSTAND THE FINANCIAL GUIDELINES AND OFFICE INSURANCE POLICIES. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR MY BALANCE REGARDLESS OF MY INSURANCE.

DATE: _____ SIGNATURE: _____

DATE: _____ SIGNATURE: _____

MEDICAL HISTORY

Name _____ Birthdate _____ File# _____

1. The name and address of your physician is _____
2. Date of your last physical exam (month/year) _____
3. Are you currently under the care of a physician? Yes No
 If yes, what is the condition being treated? _____
4. Have you ever had any serious illness, operation or hospitalization? Yes No
 If yes, please list: _____
5. Are you currently taking any medicine(s) including non-prescription or herbal supplements? Yes No
 If yes, please list: _____
6. Do you have an allergy or sensitivity to any medications and/or anesthetics? Yes No
 If yes, please list: _____
7. Do you have a latex allergy? Yes No
8. Do you have high or low blood pressure? Yes No
 If yes, which? _____
9. Do you have or have you had cardiovascular disease, including heart trouble, heart attack, stroke, angina, irregular heart rhythm or rhythm regulating device (i.e. pacemaker, defibrillator) vascular grafts or shunts, coronary insufficiency/occlusions, congenital heart defect, arteriosclerosis, or heart or blood vessel problem? Yes No
 If yes, which type? _____
10. Do you have a damaged or artificial heart valve(s) or a history of heart murmur or rheumatic fever? Yes No
11. Do you have an artificial joint(s), prosthesis, or organ transplant? Yes No
 If yes, which type? _____ Date _____
12. Do you have or have you had cancer? Yes No
 If yes, which type and how was it treated? _____

13. Circle any of the following which you have had or have at present.

- | | | |
|-----------------------------|-------------------------------|----------------------------------|
| Abnormal Bleeding | Diabetes | Problems with Mental Health |
| Anemia | Epilepsy/Neurological Disease | Recent Unexplainable Weight Loss |
| Arthritis or Painful Joints | Fainting Spells or Seizures | Respiratory Problems/Emphysema |
| Asthma | Jaundice/Liver Disease | Sexually Transmitted Disease |
| Blood Disorder | Kidney Problems | Sinus Problems |
| Blood Transfusion - When? | Osteoporosis | Stomach Problems |
| Bronchitis | Persistent Cough | Tuberculosis |
| | Problems of the Immune System | OVER |

14. Do you have or have you had hepatitis? Yes No
 If yes, which type? _____
15. Do you have AIDS or HIV infection? Yes No
16. Have you ever been tested for AIDS or HIV infection? Yes No
17. Do you use or have you used tobacco in any form? Yes No
 If yes, which type and what amount? _____
18. Do you have or have you had a history of alcohol and/or drug dependency? Yes No
 If yes, which type? _____
19. Do you have or have you had an eating disorder? Yes No
20. Do you have any other medical disease, condition, or problems not listed above? Yes No
 If yes, please explain _____

WOMEN

21. Are you pregnant? Yes No
22. Are you nursing? Yes No
23. Are you taking birth control pills? If yes, what _____ Yes No

DENTAL HISTORY

1. What is your primary dental concern? _____
2. How long since your last dental visit? _____
3. Your previous dentist's name _____
4. Have you ever had any unusual problems or complications with previous dental treatment? Yes No
 If yes, explain _____
5. Have you ever had gum treatment or surgery? Yes No

I certify the above information is complete and accurate.

Signature of Patient or Guardian _____ **Date** _____

In case of emergency call _____ **Relationship** _____