

Patient Information

Patient Name: _____ Gender: _____
Last, First MI (Preferred Name)

Home Phone: _____ Social Security No. _____

Work Phone: _____ Date of Birth: _____

Cell Phone: _____ Family Status: Dependent / Single / Married

Email address: _____

Address: _____
Street Apartment #

_____ City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? Another patient: friend / relative / coworker Physician/Dentist

Yellow Pages Internet search Insurance website Other _____

Name of person or office referring you to our practice: _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

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

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Allergies: _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | Due date: _____ | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sinus Problems | OTHER: |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tuberculosis | |

Medication: List all medications you are currently taking.

- Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____
- Are you now under the care of a physician? Yes No
If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

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.

X _____ Date: _____
Signature of Patient, Parent or Guardian

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Cellular): _____ (Work): _____ Ext: _____

Address: _____
Street City State Zip Code

Employment Information

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

Employer Name: _____ Occupation: _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

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

Insured's Employer Name: _____

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

Insurance Plan Name: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

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

Insured's Employer Name: _____

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

Insurance Plan Name: _____

Consent for Services

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

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

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 of all dental services. 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.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

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

X _____ Date: _____ Relationship to Patient: _____
Signature of Patient, Parent or Guardian

Financial Policy

Welcome to Today's Smile. Our goal is to provide you with the highest quality dental care and customer service in a friendly atmosphere. In order to avoid any misunderstanding we have outlined our office financial policy for all of our patients.

Fees are due on the day that dental services are rendered, unless previous arrangements have been made. Some services will require prepayment at time of scheduling the appointment.

We take great pride in trying to stay on schedule in order to reduce any inconvenient waiting time for our patients. Therefore we ask you to do the same; please be on time for your appointment. If you need to reschedule your appointment, a minimum of 48 hours notice is requested. For failing to keep the appointment without a minimum-24-hour notice, the patient will be charged a **\$75 Broken Appointment Fee**.

In cases where we are not participating "preferred provider" in your particular dental insurance network, we will collect fees from you according to your insurance's fee schedule. In these circumstances, we will again file your claim to your dental insurance company. If, after insurance claim had settled, you owe us any extra fee specifically due to the fact that we are out-of-network provider as opposed to being in-network-preferred-provider, the extra fee will be waived as our courtesy to you.

The following types of payment options are available in our office:

1. Cash, Credit/Debit Cards (Visa, Master Card, American Express, Discover): Payment is expected in full on the day that the services are rendered. We do not accept personal checks; but if, in the event we were to accept it and the check(s) return due to insufficient funds, there will be a \$25 charge for each returned check(s).

2. Financial Payment Plan: Our office offers No Interest Payment Plans through a financial institution outside the office. We are participating provider with CareCredit finance program in which multitude of patient payment plans are available, some are no-interest financing and others are low-interest, long-term financing. Ask our staff about the payment plan options.

3. Dental Insurance: Some of our patients have some form of dental insurance. The benefits you receive are in accordance with the terms set down at the time of the purchase of the policy. What is commonly known as "dental insurance" is more correctly termed as dental benefits. Dental benefits are not intended to pay everything, but to assist with cost of dental treatment. Please present your insurance card before or at the beginning of your first appointment so that proper filing information is obtained in order to submit insurance claims. We will contact your insurance company and obtain a breakdown of your benefits. We will then discuss these with you. As courtesy, we will be happy to file a claim on your behalf to your insurance carrier. However, you should know that we have no relationship with your insurance company, only with you. Should your dental insurance pay less than expected, you are fully responsible for the balance. We take no responsibility for any denials by your insurance plan. **Patient co-payments are due at the time of service.** If any payment is made by your insurance carrier in excess of the balance, we will place immediate credit on your account or refund the over-payment to you within 30 days upon your request.

In the rare occasion there is a balance of due payment in your account, a statement will be mailed out. That balance is due upon receipt of the statement. If your account is forwarded to a collection agency and/or attorney you will be responsible for all incurring collection fees and/or attorney fees. Also, a \$75.00 office administrative fee will be added to such account.

We sincerely thank you for choosing our practice for your dental care, and we will do our best to provide you with best possible dental care and best customer service.

I have read the above financial policies and terms, and agree to their content.

X _____
Signature of Patient, Parent, or Guardian

Date: _____

Printed Name: _____