Financial Responsibility

I understand that I am financially responsible for all charges, whether or not paid by insurance. I understand that if I do not pay the entire balance, or previously agreed upon amount, within 28 days of the monthly billing date, a finance charge of 18% (1 ½ %) will be assessed each month.

I understand that I will be charged a fee of $25.00 for any month a payment is not made on an existing balance. I realize that failure to keep this agreement will result in interruption of elective dental procedures.

I agree to pay late charges, collection costs and any other reasonable fees necessary to collect on this amount or any future outstanding balances incurred by me or a member of my family for whom I am financially responsible.

Guarantor Signature___________________________
Relationship to patient__________________________
Date___________________________
I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ________________________________________________

Signature: ____________________________________________________

Relationship to Patient: ________________________________________

Date: _______________________________
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name
______________________________________________________________

Relationship to Patient:
______________________________________________________________

Signature:
______________________________________________________________

Date
______________________________________________________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: ____________________________________________ Initials: ____________ Reason: ____________________________________________
Patient Information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name ___________________________ Date __________ SS/HIC/Patient ID# ___________________________

First Middle Initial Last

Address __________________________ City __________ State ______ Zip ______

Sex: ☐ Female ☐ Male 
Birthdate __________ E-mail __________________________

Home Phone (_____) __________ Cell Phone (_____) __________ Work Phone (_____) __________

Do you prefer to receive calls at: ☐ Home ☐ Work ☐ Cell ☐ No Preference
☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for ______ years

Patient Employer/School __________________________ Occupation __________________________

Employer/School Address __________________________ City __________ State ______ Zip ______

Spouse or parent’s name __________________________ Employer __________________________ Work Phone (_____) __________

Whom may we thank for referring you to us? ________________________________________________

Person to contact in case of emergency __________________________ Phone (_____) __________

Responsible Party

Name of person responsible for this account __________________________ Phone (_____) __________

Relationship to patient __________________________

Address __________________________ City __________ State ______ Zip ______

Name of employer __________________________ Work Phone (_____) __________

Insurance Information

Name of insured __________________________ Relationship to patient __________________________

Birthday __________ Social Security # __________ Date employed __________

Name of employer __________________________ Work Phone (_____) __________

Address __________________________ City __________ State ______ Zip ______

Insurance Co. __________________________ Group # ______ Employer # ______

Insurance Co. Address __________________________ City __________ State ______ Zip ______

How much is your deductible? ______ How much have you used? ______ Max. annual benefit? ______

DO YOU HAVE ADDITIONAL INSURANCE? ☐ No ☐ Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured __________________________ Relationship to patient __________________________

Birthday __________ Social Security # __________ Date employed __________

Name of employer __________________________ Work Phone (_____) __________

Address __________________________ City __________ State ______ Zip ______

Insurance Co. __________________________ Group # ______ Employer # ______

Insurance Co. Address __________________________ City __________ State ______ Zip ______

How much is your deductible? ______ How much have you used? ______ Max. annual benefit? ______
Dental History

Name ___________________________ Age ______ Date of last exam ______
Former Dentist ____________________ Date of last dental X-rays ______
Reason for today's visit _________
How often do you brush? ___________ How often do you floss? ________

Please check any of the following conditions that apply to you:

☐ Bad breath ☐ Grinding teeth ☐ Sensitivity to heat
☐ Bleeding gums ☐ Loose teeth or broken fillings ☐ Sensitivity to sweets
☐ Clicking or popping jaw ☐ Periodontal treatment ☐ Sensitivity when biting
☐ Food collection between teeth ☐ Sensitivity to cold ☐ Sores or growths in your mouth

Medical History

Physician __________________________ Date of last visit ______

Please list all medications you are currently taking: _______________________

Allergies: __________________________

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have had any of the following:

☐ AIDS ☐ Congenital Heart Lesions ☐ Hepatitis ☐ Rheumatic Fever
☐ Anemia ☐ Cortisone Treatments ☐ Hermia Repair ☐ Scarlet Fever
☐ Arthritis, Rheumatism ☐ Cough, Persistent ☐ High Blood Pressure ☐ Shortness of Breath
☐ Artificial Heart Valves ☐ Cough up blood ☐ HIV Positive ☐ Skin Rash
☐ Artificial Joints ☐ Diabetes ☐ Jaw Pain ☐ Stroke
☐ Asthma ☐ Epilepsy ☐ Kidney Disease ☐ Swelling of Feet or Ankles
☐ Back Problems ☐ Fainting ☐ Liver Disease ☐ Thyroid Problems
☐ Bleeding Abnormally ☐ Glaucoma ☐ Mitral Valve Prolapse ☐ Tobacco Habit
☐ Blood Disease ☐ Headaches ☐ Nervous Problems ☐ Tonsillitis
☐ Cancer ☐ Heart Murmur ☐ Pacemaker ☐ Tuberculosis
☐ Chemical Dependency ☐ Heart Problems ☐ Psychiatric Care ☐ Ulcer
☐ Chemotherapy ☐ Describe __________________________
☐ Circulatory Problems ☐ Hemophilia ☐ Radiation Treatment ☐ Venereal Disease
☐ Respiratory Disease

Have you ever taken any of these medications?

Diet Medications: ☐ Dexfenfluramine ☐ Fen-phen ☐ Pondimin ☐ Redux
Blood Thinners: ☐ Coumadin ☐ Warfarin
Other: ☐ Levoxyl ☐ Synthroid

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with __________________________

Name of Insurance Company(ies)

and assign directly to Dr. __________________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______________________________ __________________________
Signature of Patient, Parent, Guardian or Personal Representative Date

Please print name of Patient, Parent, Guardian or Personal Representative __________________________
Relationship to Patient __________________________