Medical Alert ☐

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Confidential Patient Information and Health History

Patient Instructions: Please answer the following questions by filling in the appropriate blanks. If you need help, please ask for assistance. Your thoroughness and honesty in answering these questions is of extreme importance in the diagnosis and treatment planning of your specific dental needs.

Patient Information

(Please Print)

Patient: Last Name _____ First Name _____ MI _____
Sex _____ Age _____ Date of Birth _____ Social Security Number _____
Mailing Address _____
Street Address _____
City _____ State _____ Zip _____ Home Phone _____
Work Phone Number _____ Cell Phone number _____
Who Referred You To Our Office _____

Responsible Party Information

(Please print)

Responsible Party: Last Name _____ First Name _____ MI _____
Mailing Address _____ Home Phone _____
City _____ State _____ Zip _____ Cell Phone _____
Name and Address of Employer _____ Work Phone _____

Dental Insurance Information

(Please Print)

Insured: Last Name _____ First Name _____ MI _____
Sex _____ Date of Birth _____ Social Security Number _____
Mailing Address _____
Street Address _____
City _____ State _____ Zip _____ Home Phone _____
Name of Employer _____
Employer Phone Number _____
Name of Insurance Company _____ Group Number _____
Insurance Company Address _____
Insurance Company Phone Number _____ Subscriber/Member ID# _____

***** DO YOU HAVE MEDICAID? *** ____ No ____ Yes**

Patient Medical Information

(Please Be Thorough and Honest)

Name and address of personal physician _____

Please check if you have had or have any of the following:

___ Arthritis	___ Diabetes	___ Radiation Treatment	___ Tuberculosis
___ Dementia	___ Kidney/Bladder Trouble	___ Chemical Dependencies	___ Glaucoma
___ Heart Trouble	___ Lung Disease	___ Prosthetic Joint Replacement	___ HIV or AIDS
___ High/Low Blood Pressure	___ Venereal Disease	___ Blood Transfusion/ Year	___ Stroke
___ Blood Disease/Problems	___ Currently Pregnant	___ Cancer or Tumor	___ Mental Disorders
___ Asthma or Hay Fever	___ Fainting Tendency	___ Facial Injury/ Date	___ Epilepsy
___ Liver Disease/Hepatitis	___ Thyroid Disease	___ Cold Sores/Blisters	___ Eating Disorders

Are there any other medical conditions, which you feel need to be mentioned? _____
Please list past or current tobacco use: _____
Have you seen or been treated by a Mental Health Provider? _____
List any medications you are currently taking: _____
List any allergies you may have: _____

Please read and sign back of this sheet.

Our Financial Policy

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

Payment:
*Payment is due at time of service
*We accept cash, check, or major credit cards
*Estimated co-payment on insured patients is due at time of service
*For procedures requiring out of office lab fees such as crowns, bridges, and dentures we request ½ down or your co-payment on the first visit

Insurance:
*Insurance is a contract between you and your insurance company, we are not a party to the contract
*We will file insurance claims as a courtesy to our patients
*We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary.
*You are responsible for knowing what your insurance company covers

Past Due Accounts:
*1 ½%per month finance charge is accrued on accounts over 30 days old

Returned Check Fees:
*A $20 returned check fee will be added to the account balance
*Repayment of the check and incurred fee must be made in cash
*Prosecution may result from checks that have been written on closed accounts or that have not been redeemed with cash

Collections:
*Every attempt will be made to collect on an account
*Unsuccessful collection actions from our billing office will result in the account being sent to a collection agency with an additional collection agency fee included. Of course this will negatively impact any credit report.

Missed Appointments:
*Unless an appointment is cancelled at least 24 hours in advance there will be a missed appointment fee charged to your account balance
*Special circumstances such as illness, weather or family emergencies will be considered

The information given is true to the best of my knowledge, if there are changes I will notify the office.

_____ _____ Date: _____
Patient Signature
(Parent signature is required if patient is under 18 years of age)

_____ Date: _____
Signature of person responsible for payment of account