Family Dental & Implant Center

Patient Information

Patient Name:_____ **Date:**_____

☐ Married ☐ Single ☐ Child ☐ Divorced ☐ Widow ☐ Male ☐ Female

Social Security #: _____ **Birth Date:** _____

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

Address:_____

Street Apartment #

_____

City State Zip Code

EMAIL ADDRESS: _____

HEALTH INFORMATION

Reason for this visit: _____

Have you ever had any of the following? ***Please check the box Yes or No:***

☐Y☐N AIDS
☐Y☐N Allergies_____
☐Y☐N Latex Allergies
☐Y☐N Anemia
☐Y☐N Arthritis
☐Y☐N Artificial Joints
☐Y☐N Asthma
☐Y☐N Blood Disease
☐Y☐N Cancer
☐Y☐N Diabetes
☐Y☐N Dizziness
☐Y☐N Epilepsy
☐Y☐N Excessive Bleeding

☐Y☐N Fainting
☐Y☐N Glaucoma
☐Y☐N Growths
☐Y☐N Hay Fever
☐Y☐N Head Injuries
☐Y☐N Heart Disease
☐Y☐N Heart Murmur
☐Y☐N Hepatitis A_B_C_
☐Y☐N High Blood Pressure
☐Y☐N Jaundice
☐Y☐N Kidney Disease
☐Y☐N Liver Disease

☐Y☐N Mental Disorders
☐Y☐N Nervous Disorder
☐Y☐N Pacemaker
☐Y☐N Pregnancy
Due date:_____
☐Y☐N Radiation Treatment
☐Y☐N Respiratory Problems
☐Y☐N Rheumatic Fever
☐Y☐N Rheumatism
☐Y☐N Sinus Problems
☐Y☐N Stomach Problems

☐Y☐N Stroke
☐Y☐N Tuberculosis
☐Y☐N Tumors
☐Y☐N Ulcers
☐Y☐N Venereal Disease
☐Y☐N Codeine Allergy
☐Y☐N Penicillin Allergy
Have you taken PHEN PHEN
☐Y☐N _____
Other
☐Y☐N _____

- **Are you currently on any medications?** ☐ Yes ☐ No
  If yes, please list: _____
- **Have you ever had any complications following dental treatment/or with anesthetics?** ☐ 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 proceeding 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. I have received the patient acknowledgment of receipt of dental materials fact sheet. I received the Health Information Privacy. I consent to receiving texts and/or emails from this office.

_____ _____ **Date:**_____

Signature of patient, parent or guardian **Reviewed By:**

EMERGENCY CONTACT INFORMATION:

IN CASE OF EMERGENCY WHO MAY WE CONTACT?

_____

Family Dental & Implant Center

RESPONSIBLE PARTY INFORMATION

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

Name: _____

Social Security #: _____ **Birth Date:** _____

Phone (Home): _____ **(Work):** _____ **Ext:** _____ **Best time to call:** ___

Address _____
Street Apartment #

_____
City State Zip Code

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: _____

Address: _____
Street City State Zip Code

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

Insurance Plan Name and Address: _____

_____

Secondary

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

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

Insured's Employer Name: _____

Address: _____
Street City

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

Insurance Plan Name and Address _____

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. ACCOUNT WILL BE REPORTED TO THE AMERICAN CREDIT BUREAU.

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 and agree to their content. _____ (patient) Date: _____

Signature of parent/guardian_____ Date: _____

OFFICE POLICY

Thank you for choosing our office! We are committed to providing you with a bright and friendly atmosphere that offers excellent service and treatment. Please help us by following these policies.

1. Our practice is committed to providing the best treatment possible for our patients. Our diagnosis will always be based on what is in the best interest of our patients, not arbitrary insurance coverage or cost.
2. We will inform you of your estimate prior to beginning any treatment. Please keep in mind that this is **only an estimate**, and may be subject to change.
3. Payment in full is due on or before the time of service. We accept cash, checks, Visa, Master Card, Discover & Care Credit. A fee will be charged for any returned checks & will be your responsibility.
5. Please be aware that some, and perhaps all of the services provided may be **"non-covered"** and/or not considered **"reasonable and necessary"** under some insurance carriers. This does not negate your responsibility for the charges incurred. You as the patient are ultimately responsible for the entire balance for services rendered.
6. If your insurance company has not paid your account in full, the balance will automatically be transferred to you & will be your responsibility.
7. Once a statement is sent to you, a late fee will be charged every 30 days your balance is not paid in full. Any collection fees we incur will be transferred to you & become your responsibility.
8. Accounts with an open balance will require payment in full prior to scheduling any subsequent appointments.
9. All original X-rays & chart notes are the legal property of this office & cannot be released. Duplicates of X-rays or any other part of your chart may be provided for a fee upon request.
10. Cancelled, Rescheduled, or Missed Appointment policy: **There is a charge of $75 per patient** for not showing on scheduled appointments. Repeated cancellations or missed appointments will result in loss of future appointment privileges. First missed appointment will be a reminder. Any failed appointments after, will be charged, & expected to be paid prior to rescheduling future appointments. **If you need to cancel or reschedule an appointment, please notify us at least 2 business days in advance. Please note if you are scheduled with our specialist the cancel or reschedule time is one week in advance.**
11. Minor **MUST always be accompanied** by a responsible adult whom is responsible for payment of the service on their appointment.
12. I grant my permission to Family Dental and Implant Center to text me and or email me with reminders of my appointment or any other necessary communication such as billing, treatment reminders, etc.
13. I agree to receiving text to pay on my cell phone: Yes / No

By signing below, I acknowledge that I have read, understood & agree to the above stated Consent for Services. I understand that I am responsible for keeping my appointments, & ultimately responsible for all charges.

Signature: Date: