## Patient Information

Date:_____

Patient Name: _____ Preferred_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Birth Date: _____ Social Security #: _____

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

Email: _____

Address: _____
Street Apartment #

_____
City State Zip Code

## Health Information

Date of Last Dental Visit: _____Reason for this visit:_____
What do you dislike about your smile?_____

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

☐ AIDS
☐ Allergies _____
_____
☐ Codeine Allergy
☐ Penicillin allergy
☐ Sulfa Allergy
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy**
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
OTHER:
☐ _____
☐ _____

**Medications:**_____
_____
_____
_____
_____

- 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.

_____ 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 _____

Birth Date: _____ Social Security #: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

## Employment Information

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

Employer Name: _____ Phone: _____

Address: _____
Street City State Zip Code

## Dental 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: _____

_____

Insurance phone: _____

**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 State Zip Code

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

Insurance Plan Name and Address: _____

_____ Phone: _____

## Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐Mailer ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

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

## 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.

_____ **Date:** _____ **Relationship to Patient:** _____
**Signature of patient, parent or guardian**

## Acknowledgement of Privacy Policy

I acknowledge that I received and reviewed the Privacy Policy Notice for the office of Lost Creek Dental.

_____ **Date:** _____
**Signature of patient, parent, or guardian**

In the case you do not agree to sign this form, our office must indicate why you decline to do so. Reason for patient, parent, or guardian's refusal:

_____

_____

**Privacy Director's signature:** _____ **date:** _____

Sister Creek
DENTAL

## FINANCIAL POLICY

As we enter this doctor-patient relationship, we agree to provide quality healthcare at a fair and reasonable price. You in turn, agree it is your obligation to be prepared to pay at the time of service and to understand the benefits of your insurance. We want to explain our financial policy to you so there are no unpleasant surprises.

- **Co-payments, deductibles and/or coinsurance are due at the time of service.** We accept Cash, Personal Check, Visa, MasterCard, Discover, American Express and Care Credit. If you are not prepared to pay the required amount, we are required to reschedule the appointment. The estimated financial responsibility for scheduled services will be due at the time services are provided unless earlier arrangements have been made. Any remaining balance after your health plan pays will be due upon receipt of a statement. If insurance coverage cannot be verified prior to the appointment, the account will be notated as private pay and payment will be due in full. *Account balances over* 90 *days with no payment activity will be reported to the credit bureau.* **Initials** _____

- **Your insurance policy is a contract between you and your insurer. Do not assume your policy covers everything or pays 100%. It is your responsibility to know what your policy covers and what it does not. We cannot guarantee your benefits.** Any item deemed "non-covered" by your insurance carrier will be your financial responsibility. Any disputes about payment must be resolved between you and your insurance company. Failure to provide accurate insurance information within 3 days from the date of service will result in the balance becoming your financial responsibility. **Initials** _____

- **As a courtesy to you, we will file primary participating insurance for you.** Please bring your insurance card with you to every visit. I understand that all remaining balances are my responsibility to satisfy prior to additional services being rendered. **Initials** _____

- **A $35.00 fee will be assessed for all returned checks. A $50.00 fee will be added to your account each time a cancellation is made without providing 24 hours notice.** We understand that emergencies happen and we will take that in to consideration if the need arises. **Initials** _____

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice at any time.

_____ _____

Responsible Party Printed Name Date

_____

Responsible Party Signature