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What do you dislike about y			90,01,05			
Have you ever had any of □ AIDS	the following? Please chec Epilepsy	k those that apply:  • Mental Disorders	□ Ulcers			
□ Allergies	☐ Excessive Bleeding	□ Nervous Disorders	□ Venereal Disease			
- Alleigles	☐ Fainting	□ Pacemaker	OTHER:			
☐ Codeine Allergy	□ Glaucoma	□ Pregnancy	Transition of the state of the			
☐ Penicillin allergy	□ Growths	Due date:	П			
☐ Sulfa Allergy	☐ Hay Fever	Radiation Treatment				
☐ Anemia	☐ Head Injuries					
□ Arthritis	☐ Heart Disease	Rheumatic Fever	MEGICALIONS			
□ Artificial Joints	☐ Heart Murmur	□ Rheumatism	or provide to to swy or to			
□ Asthma	□ Hepatitis	☐ Sinus Problems				
□ Blood Disease	☐ High Blood Pressure	☐ Stomach Problems	- 2-1 <del>- Grand - Standistand</del>			
Concer	□ laundice	□ Stroke	and the state of t			
□ Diabetes	☐ Kidney Disease	☐ Tuberculosis	a contract to a contract the			
□ Dizziness	☐ Liver Disease	□ Tumors				
<ul> <li>Have you ever had any co</li> </ul>	emplications following dental tr	eatment? ☐ Yes ☐ No				
	5 - 10 - 10 - 10 - 10 - 10 - 10 - 10 - 1					
<ul> <li>Have you been admitted to</li> </ul>	o a hospital or needed emerge	ency care during the past two	years? □ Yes □ No			
Are you now under the cal     If yes, please explain:	re of a physician?	a sub-rai CONCRADA a Company	to called the second in			
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If yes, please explain:	oblems that need further clarif	and the second				
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## 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
	have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and ree that such terms may be amended by the practice at any time.
R	Responsible Party Printed Name Date
Re	esponsible Party Signature