

Office Policies

Please read, initial each section, and sign below.

_____PAYMENT: Payment in full is expected at the time services are rendered. We accept cash, checks, MasterCard, VISA, Discover, and CareCredit. A returned check fee of \$30.00 will be assessed for any check payment that is returned due to insufficient funds. Subsequently, payment options for patients or accounts with returned items may be limited to cash or credit card.

_____DENTAL INSURANCE: If we agree to accept assignment of benefits from a dental insurance company, patients must pay for any portion of the charges not covered as services are rendered. If payment for any dental claim is not received within 45 days, you will receive a statement for the entire balance due. If payment is not made within 45 days of receipt of the statement, your account may be turned over to collections. Charges that are denied or not covered by the insurance company are the responsibility of the patient or guardian.

_____COLLECTION COSTS: Account balances more than 45 days past due may be sent to collections. Patients will be responsible for costs of collections including, but not limited to, collection agency fees, attorney fees and court costs.

_____PATIENT AND INSURANCE INFORMATION: The patient will be responsible for informing the office of any changes to the following: mailing address, phone numbers, emergency contact information, insurance plan information, and changes in medical history, including the list of medications you are currently taking.

_____BROKEN APPOINTMENTS: A missed appointment or late cancellation charge of \$25/hour will be assessed for any appointment that is missed, or for any appointment that is cancelled with less than 24 hours notice.

_____HIPAA: I have reviewed and/or received a copy of the office's Notice of Privacy Practices.

_____QUESTIONS: Open communication is an important part of ongoing treatment and is essential if we are to keep you well informed and happy with our services. If you have any questions regarding your bill or dental treatment, please ask for clarification or additional information.

By signing below, I acknowledge that I have read, understood, and agree to the above office policies. I also understand that I am ultimately financially responsible for any balance on my account.

Signature: _____ Date: _____

Medical History

Name: _____ Date: _____

Primary Care Physician (medical): _____ Phone #: _____

Please list all medications you are currently taking: 1) _____

2) _____ 3) _____ 4) _____

5) _____ 6) _____ 7) _____

8) _____ 9) _____ 10) _____

Allergies to medications: _____

Allergy to latex: Yes No

(Women) Are you pregnant? Yes Due Date: _____ No Nursing? Yes No

Are you taking birth control pills/hormone replacement therapy? Yes No

Please check if you have ever or now have any of the following:

<input type="checkbox"/> AIDS / HIV	<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Respiratory Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cortisone Treatments	<input type="checkbox"/> Hepatitis A / B (circle)	<input type="checkbox"/> COPD
<input type="checkbox"/> Arthritis, Rheumatism	<input type="checkbox"/> Congenital Heart Disease	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Cough - persisant, or with blood	<input type="checkbox"/> Herpes	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Artificial Joint (circle) Knee / Hip	<input type="checkbox"/> Diabetes (Family History)	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke
Other: _____	<input type="checkbox"/> Epilepsy / Seizures	<input type="checkbox"/> Immunosuppressive Drugs	<input type="checkbox"/> Chemical Dependency
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fainting/Dizziness	<input type="checkbox"/> Infective Endocarditis	<input type="checkbox"/> Swelling of feet/ankles
<input type="checkbox"/> Auto Immune Illness	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Intestinal Disorder	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Kidney Disease Dialysis	<input type="checkbox"/> Tobacco Habit
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Heart Problems: _____	<input type="checkbox"/> Kidney Transplant	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Heart Transplant	<input type="checkbox"/> Nervous Problems	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Radiation Treatment		<input type="checkbox"/> Pace Maker	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Surgery		<input type="checkbox"/> Parkinson's	<input type="checkbox"/> Headaches (chronic)
			<input type="checkbox"/> Bisphosphonate Medication (for bones)

Please list any other medical conditions that we should be aware of: _____

Are you under the care of a specialist for any of these conditions? Yes No

Name of Specialist (If 'yes'): _____ Phone: _____

To the best of my knowledge, all of the preceding information provided is true and complete. If I ever have any change in my health, I will inform the doctors at the next appointment.

Signature of patient, parent or guardian _____ Date: _____