PATIENT REGISTRATION AND MEDICAL HISTORY FORM

(Please Print)

DATE _____ HOME PHONE _____ CELL PHONE _____ Driver License # _____

PATIENT _____
LAST NAME FIRST NAME MIDDLE INITIAL

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

SEX: □ M □ F AGE _____ Birth date _____ □ Single □ Married □ Widowed □ Divorced

PATIENT SOCIAL SECURITY # _____

EMPLOYED BY _____ OCCUPATION _____

BUSINESS ADDRESS _____ BUSINESS PHONE # _____

DENTAL INSURANCE COMPANY _____ GROUP # _____

SPOUSE/PARENT NAME _____ SPOUSE/PARENT DATE OF BIRTH _____

SPOUSE/PARENT S.S. # _____

SPOUSE/PARENT EMPLOYED BY _____ OCCUPATION _____

BUSINESS ADDRESS _____ BUSINESS PHONE # _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____

IN CASE OF EMERGENCY, WHO SHOULD WE NOTIFY? _____ PHONE # _____

MEDICAL HISTORY

PHYSICIAN'S NAME _____ DATE OF LAST PHYSICAL _____

Have you ever had any of the following? (Check the box that applies):

□ Heart Murmur
□ High Blood Pressure
□ Low Blood Pressure
□ Circulatory Problems
□ Nervous Problems
□ Radiation Treatment
□ Artificial Heart Valves or Joints
□ Recent Weight Loss
□ Back Problems
□ Diabetes
□ Respiratory Disease
□ Digestive System (Acid Reflect)
□ Epilepsy
□ Headaches
□ Hepatitis, Jaundice or Liver Disease
□ Cancer
□ Psychiatric Care
□ Chronic Diarrhea
□ Allergies to Anesthetics
□ Allergies to Medicines or Drugs
□ General Allergies
□ Blood Disease
□ Arthritis
□ Osteoporosis
□ Special Diet
□ Swollen Neck Glands
□ Rheumatic Fever
□ Sinus Problems
□ "AIDS" or other Immunosuppressive Disorders
□ Stroke
□ Ulcer
□ Venereal Disease
□ Chemical Dependency
□ Hemophilia

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____ If so, what? _____

Have you ever responded adversely to a medical or dental treatment? _____

Are you taking any medication at this time? _____ Is so, what _____
Are you taking any medication over the counter? Vitamins? Any other supplements? _____
Are you under the care of a physician? □ Yes □ No
For what conditions? _____
If Patient is a child, what is his/her weight? _____
(Women) Do you suspect that you are pregnant? □ Yes □ No Are you nursing? □ Yes □ No
Is there anything else we should know about your medical history? _____

The above patient information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of hi/her staff responsible for any errors or omissions that I may have made in the completion of this form.

DATE: _____ SIGNATURE" _____ (OVER)

AUTHORIZATION TO RELEASE INFORMATION AND AUTHORIZATION OF PAYMENT OF BENEFITS

I hereby authorize . to provide any insurance company(s), claim administrator(s) and consulting healthcare professional(s), information concerning health care, advice, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize payment directly to C. Dental. I agree that a photocopy of this authorization is as valid as the original.

Signature_____ Date_____
(if patient is a minor, Parent or Guardian must sign here and complete section below)

PAYMENT AGREEMENT

I understand and agree that payment is due at the time services are rendered and that health, dental and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that this office will prepare any necessary dental reports and dental forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment, regardless of insurance.

In the event my account balance is referred to any agency or attorneys for collection purposes, I agree to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs.

In the event that the patient is a minor, I am the parent and/or guardian of said patient and agree that I am responsible for all services rendered to the patient herein.

I understand that if I suspend or terminate any care and treatment to me or to any person referred to in the previous sentence, any fees for professional services rendered will be immediately due and payable.

Signature_____ Date_____
(if patient is a minor, Parent or Guardian must sign here and complete section below)

RESPONSIBLE PARTY

(Dr/Mr/Mrs/Ms/Miss) First Middle Last Jr/Sr

SSN DOB M or F Sex

Street City State Zip

( ) ( )
Home Phone Work Phone May we contact you by Email? Y N (Please enter email address)

METHOD OF PAYMENT

How will you pay for today's visit? ☐ Cash ☐ Bank Check ☐ *Care Credit ☐ *Unicorn ☐ Charge Card

☐ Other_____ ***See Receptionist for Application Forms**

Charge Card Authorization

By signing hereunder, I hereby authorize _____ to bill my charge card account should any balance for services rendered remain outstanding for more than (60) sixty-days. If the account information given expires or is otherwise discontinued, I agree to give C. Dental information as to an alternate charge account, which may be used. My account is as follows:

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express Card #_____ Exp Date_____

Signature_____ Date_____

Treatment Plan Release

The above information is accurate and complete to the best of my knowledge and is only used in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

DATE:_____ SIGNATURE:_____

PRACTICE/PATIENT AGREEMENT

Please read and sign the following form. By signing this page, you are accepting the terms and conditions set forth below.

1. Federal regulations require xrays to remain property of the dental office. If you request copies of your xrays, there will be a $25.00 charge per copy.
2. If an appointment is cancelled less than 24 hours in advance with a general dentist, a $25.00 fee will be charged to your account. If an appointment is cancelled less than 24 hours in advance with a specialist, a $50.00 fee will be charged to your account.
3. Some insurance companies do not cover consultations with specialists. If your insurance company does not cover the consultation visit, you will be charged the amount allowed by your insurance company.
4. Some insurance companies only cover amalgam (silver) fillings on a back tooth. If you have composite (tooth colored) filling done, you will be responsible for the difference in price of the two in addition to the percentage you must pay based on your insurance plan. Please make sure you ask the doctor prior to having a filling completed.
5. Most specialist services and prosthetic work requires a pre-determination of benefits. We will send in the required information at no charge. Note a pre-determination of benefits does not guarantee payment if other work was completed from the time it was sent. If your treatment is done prior to approval, you will be responsible if your insurance company does not cover the service.
6. Prior to any prosthetic work (crowns, bridges, dentures, for example) you will be required to pay 50% of your portion to cover preparation work and laboratory fees. These fees will not be reimbursed if you choose not to finish treatment.
7. Payment is due on the day of service. The amount you are told to pay is an estimate based on what we expect your insurance company to pay. This does not guarantee payment by your insurance. If your insurance does not pay in full or pays partially, you will be responsible for any balance that is incurred.
8. Any payment not made within 30 days of notice will receive a finance charge of 18% of the balance. Any payments not made within 90 days will accrue finance charges, late fees, legal expenses, and collection fees.
9. If you receive a bill and do not understand it, you are responsible for calling the office to receive an explanation.

Print Name:_____ Date:_____

Signature:_____