

HOW DID YOU HEAR ABOUT US?

Friend/Family Member: Name _____ Sign/Walked-in Post Card Ads
 Internet Search Thru insurance Office Sign Other _____

PATIENT INFORMATION

Patient Name: _____ Date: _____

Male Female Married Single Child Other _____
Last First MI

Social Security #: _____ Birth Date: _____ EMAIL: _____

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

Preferred appointment times: Morning Afternoon Evening Any Time M T W Th F S

Address: _____
Street Apartment #

City State Zip Code

EMERGENCY CONTACT: Spouse Family Member Responsible Party

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

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

Address: _____
Street Apartment #

City State Zip Code

MEDICAL HISTORY

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

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| _____ | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever | OTHER: |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaundice | | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Anemia | |

Are you pregnant? Yes No if yes, how many months? _____ Are you nursing? Yes No

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: _____

Are you taking any prescription or over-the-counter drugs? Yes No

Please list each one: _____

Do you smoke or use tobacco products? Yes No

Do you have any health condition's that need further clarification? Yes No

If yes, please explain: _____

DENTAL HISTORY

What is the reason for your visit today? Check-up Cleaning Toothache

Other: _____

Do you require antibiotics before dental treatment? Yes No

Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

Are you currently or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Yes No

Your current health : Good Fair Poor

Date of Last Dental Visit: _____

How many times a week do you floss? _____

How many times a day do you brush? _____

Do you like your smile? Yes No

Do you gum ever bleed? Yes No

INSURANCE / DENTAL PLAN

Primary insurance (circle one): PPO HMO

Secondary insurance (circle one): PPO HMO

Plan Name: _____

Plan Name: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature of patient, parent or guardian

Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

WARRINGTON DENTAL ARTS
OFFICE POLICY

INSURANCE POLICY:

YOUR INSURANCE PLAN IS A CONTRACT BETWEEN YOU AND YOUR INSURER.

AS A COURTESY WE CHECK PATIENTS ELIGIBILITY AND ESTIMATE COPAYS IN OFFICE. IT IS YOUR RESPONSIBILITY TO KNOW AND UNDERSTAND THE **TERMS, GUIDELINES, AND LIMITATIONS** OF YOUR PLAN. IT IS YOUR RESPONSIBILITY TO INFORM US OF ANY CHANGES TO YOUR, ADDRESS, INSURANCE POLICY, OR CONTACT NUMBER. A CURRENT AND VALID PHOTO ID & INSURANCE CARD IS REQUIRED, AND MUST BE PRESENTED AT EACH VISIT. IF ANY SERVICES FOR ANY REASON ARE NOT COVERED BY YOUR INSURANCE PLAN YOU WILL BE RESPONSIBLE FOR 100% OF BILLED CHARGES.

CANCELLATIONS-MISSED APPOINTMENTS:

CANCELLATIONS AND MISSED APPOINTMENTS INCONVENIENCE OTHER PATIENTS AND STAFF.

IF YOU NEED TO CANCEL YOUR SCHEDULED APPOINTMENT, WE REQUIRE AT LEAST **24 HOURS** CANCELLATION NOTICE. ANY MISSED APPOINTMENTS WILL RESULT IN A **\$30.00** LATE FEE CHARGE. IF YOU ARE SCHEDULED FOR A **SURGICAL OR COSMETIC PROCEDURE**, WE REQUIRE **48 HOURS** CANCELLATION NOTICE, FAILURE TO DO SO WILL RESULT IN A **\$75.00** LATE FEE CHARGE. ALL LATE FEES MUST BE PAID BEFORE YOUR NEXT APPOINTMENT. FAILURE TO FOLLOW THE MISSED APPOINTMENT POLICY MAY RESULT IN OFFICE DISMISSAL.

PAYMENT:

ALL CO-PAYS, CO-INSURANCE AMOUNTS, DEDUCTIBLES, AND NON-COVERED CHARGES ARE THE INSURED/PATIENT'S FINANCIAL RESPONSIBILITY, AND ARE DUE AT THE TIME OF YOUR APPOINTMENT. IF YOU ARE NOT PREPARED TO PAY YOUR OUT OF POCKET COST YOU MAY BE ASKED TO RESCHEDULE YOUR APPOINTMENT. PAYMENTS SHOULD BE MADE WITH CASH, CREDIT CARD, OR MONEY ORDER.

BALANCES:

AS A COURTESY TO OUR PATIENTS IF YOU HAVE A PAST DUE BALANCE YOU WILL RECEIVE INVOICE NOTICES AND PHONE CALL REMINDERS. IF YOUR BALANCE IS NOT PAID BY THE ASSIGNED DUE DATE AND YOU HAVE MADE NO ATTEMPT TO CONTACT THE OFFICE, YOUR ACCOUNT WILL BE TRANSFERRED TO A THIRD PARTY COLLECTION AGENCY.

CHECK FEE:

A FEE OF \$25.00 WILL BE CHARGED FOR ANY CHECK'S RETURNED DUE TO INSUFFICIENT FUNDS.

I HAVE READ, FULLY UNDERSTAND, AND AGREE TO THE TERMS OF THE OFFICE POLICY(S).

X _____ (PRINT NAME)

X _____ (PATIENT/GUARDIAN SIGNATURE)

X _____ (DATE)