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Patient Information

Date _____

Patient Name: _____ Date of Birth _____
Last First MI (Preferred Name)

Male Female Single Married Child Other Social Security#: _____ DL#: _____

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

Email Address: _____ Which way do you prefer that we contact you? _____

Address: _____
Street Apartment #

City State Zip Code

Employer Name _____ Occupation _____

Health Information

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

- | | | |
|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Migraine? _____ | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hepatitis, type? _____ | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer, type? _____ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Diabetes, type? _____ | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Excessive Bleeding, please explain what caused it _____ | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervous Disorders | Please list any other drug allergies not mentioned here _____ |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Oral Cancer or lesion | _____ |
| <input type="checkbox"/> Gum Disease | <input type="checkbox"/> Pacemaker | _____ |
| | <input type="checkbox"/> Pregnancy (presently) | _____ |
| | Due date: _____ | _____ |
| | <input type="checkbox"/> Radiation Treatment, When? _____ | _____ |
| | <input type="checkbox"/> Respiratory Problems | _____ |

Please list any PRESCRIPTION and/or OTC (Over The Counter) drugs you are currently taking, including vitamins or herbs.

Is there anything not listed here concerning your medical history we need to know about? 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: _____

Referral Information

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

Dental Office Yellow Pages Newspaper School Work Other _____

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

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 _____

Social Security #- _____ Birth Date: _____

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: _____ Occupation: _____

Do we have your permission to contact you at your work number? Yes No

Address: _____
Street City State Zip Code Phone

Insurance Information

Primary
Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

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

Insurance Plan Name and Address: _____

Secondary
Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

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

Insurance Plan Name and Address: _____

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 1% per month (1 8% 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.

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

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____

New Patient Insurance Registration Form

Understanding your insurance coverage can be challenging. Our goal is to assist you in maximizing your benefits. We care for patients from many different companies. Each company pays an insurance premium for specific coverage which fits the company budget. Each plan is slightly different with lower premium plans covering fewer services and lower fees for services. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments.

Our courtesy service to you includes:

1. Filing your insurance within 24 hours of your visit and requesting payment of your benefit to our office.
2. Electronically filing your insurance for short turn around.
3. Researching your dental insurance plan to advise you of estimated benefits available to you.
4. Re-filing your insurance a second time at 30 days and a final time at 60 days.
5. Following the American Dental Association guidelines for coding procedures and filing insurance.

Our expectations of you as the owner of the policy:

1. Payment of fees not covered by your insurance plan at the time the service is delivered.
2. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
3. Taking responsibility for payment if the insurance company does not pay our office within 75 days.
4. Keeping our office informed of any changes in your insurance coverage or employment.

To assist us in obtaining your benefits, **Please sign the "assignment of benefits" below** to allow us to file your insurance claims. Also, please have your insurance card ready for us to copy for our file.

I hereby authorize Dr. Maria Barden to release to my insurance company, information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Dr. Maria Barden. I understand I am responsible for any unpaid balance.

Signature of Patient/Insured

Date_____

Important Information For Our Patients

Dental Insurance:

We are glad to assist you with your dental insurance plan. To help us assist you in obtaining your maximum benefit, please ***bring your insurance explanation booklet, your dental insurance card, and a completed claim form to your first visit.*** Once your plan coverage has been verified, we will accept assignment of payment from your insurance company. Most plans only cover a portion of the dental fee, which means you will be responsible for your deductible and any portion your plan does not cover. Payment of your estimated portion is expected at the time you are in our office for dental care.

Payment Options:

For your convenience, we accept VISA, MasterCard, American Express, Discover and personal checks. Your co-payment can also be put on a CareCredit Account, our in-office financing partner. Applications for CareCredit are available at our front office or you can call ahead at (800) 365-8295.