PATIENT INFORMATION

Date_____
Patient's Name_____ Preferred Name_____
Birthdate _____ Patient Social Security Number_____
Address_____City_____Zip_____
Email_____(for appointment confirmations)
Home Phone#_____ Cell Phone #_____
Work Phone#_____ May we call you at work? _____
Patient's Employer_____ Address_____
Spouse's Name_____ Spouse Soc. Sec. #_____
Spouse's Employer_____ Address_____

Person to contact in case of emergency _____
Address_____ Phone_____ Relationship_____

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT

Name of responsible party_____ Relationship_____
Residence Address_____ City _____ Zip Code_____
Birthdate_____ Email _____
Home Phone_____ Social Security Number_____
Employer_____ Number of years employed _____
Employer's Address _____ City _____ Zip Code _____
Union Local Number_____ Business Phone _____
Will dental insurance be involved?_____ If yes, please complete next section.

DENTAL INSURANCE

First Coverage
Employee's Name_____ Birthdate _____
Employer_____Years_____
Name of Insurance Company _____Phone:_____
Insurance Company Address _____City _____State_____ Zip_____
Insurance I.D. # _____ Group #_____ Social Security Number_____
I authorize release of any information relating to this claim.
Name_____Date_____
I authorize payment directly to the dentist of the group insurance benefits otherwise payable to me.
Name_____Date_____

Second Coverage
Employee's Name_____ Birthdate _____
Employer_____Years_____
Name of Insurance Company _____Phone:_____
Insurance Company Address_____ City _____ State _____ Zip_____
Program/Policy #_____ Group #_____ Social Security Number_____
I authorize release of any information relating to this claim.
Name_____Date_____
I authorize payment directly to the dentist of the group insurance benefits otherwise payable to me.
Name_____Date_____

Medical History

Patient Name: _____ Date of Birth: _____

Physician's Name: _____ Physician Phone: _____

Please answer the following questions as completely as possible (circle YES or NO)

Are you now or have you been under a physician's care within the past year? If yes, specify condition being treated_____	YES	NO
Do you consider yourself to be in good health?	YES	NO
Do you take any medications, including birth control pills? Please specify name and purpose of medications: _____ _____ _____	YES	NO
Have you ever had an unusual reaction or are you allergic to any Medications, materials, or chemicals? Specify_____	YES	NO
Do you have or have you ever had any heart or blood problems?	YES	NO
Have you ever taken Phen-Fen or similar appetite suppressant? If yes, have you seen your physician for a cardiac evaluation?_____	YES	NO
Have you ever been told that you have a heart murmur?	YES	NO
Do you require antibiotic pre-medication for a heart condition, artificial valve, Artificial joint, other implant prosthesis or other condition?	YES	NO
Do you have or have you ever had high blood pressure?	YES	NO
Do you bruise or bleed easily?	YES	NO
Have you ever been diagnosed as being HIV positive or having AIDS?	YES	NO
Have you ever had any of the following: (please circle)? Rheumatic fever / Asthma / Blood Disorder / Diabetes / TB / Heart attack Kidney disease / Immune System Disorder / Other Disease _____	YES	NO
Do you currently use or have you ever used tobacco products? Specify_____	YES	NO
WOMEN- Are you pregnant? If yes, how many weeks? _____	YES	NO

Dental History

What is the purpose for your visit today?_____

_____

Is there anything in your mouth that is of concern to you? _____

_____

What is your impression of your dental and oral health?_____

When was your last dental visit? _____

Is there anything you would like to share about previous dental visits? _____

_____

Do you clench or grind your teeth or have frequent jaw soreness? _____

Do you have any special needs you would like us to be aware of? _____

_____

I am interested in learning about the following (circle all that apply):

Teeth Whitening / Smile Makeover / Laser Dentistry / Natural Looking Fillings / Implants / Sedation/ Migraine Prevention / Sealants / Invisalign or Braces / Other _____

Do you get cankers or cold sores? _____

How did you learn about our office? _____

If you were referred, who may we thank for referring you? _____

_____

Signature of Patient, Parent, or Guardian **Date** **Relationship to Patient**

Revised 9-27-06

OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, 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 or by debit/credit card at the time services are rendered.

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 insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. A fee will be assessed to any returned checks. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination.

In consideration for the professional services to be rendered to me, or at my request, to my minor child or ward by the dentist, I agree to pay the fees charged for the dental services provided to the dentist or his assignee at the time services are rendered, or within five (5) days of billing if credit shall be extended. I agree to pay the remaining balance plus reasonable attorney fees, court costs and a collection agency commission of 42% of the delinquent balance if the account is assigned to a collection agency or attorney. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to allow this office to leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial agreements or quality of care are null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

Signature of Patient, Parent, or Guardian	Date	Relationship to Patient

(Over)

CONSENT TO PROCEED

I authorize Boyden Dental and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising; hematoma; cardiac stimulation; muscle soreness; and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of dental treatment, including preventive procedures such as cleanings and basic dentistry including fillings of all types, and that although every effort and precaution will be made to ensure your comfort, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek, or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name:_____
(Please print)

Signature:_____ Date:_____
(Patient, legal guardian or authorized agent of patient)

Witness:_____ Date:_____

(Over)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

_____

For Office Use Only

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify) _____

_____