PATIENT INFORMATION

Date _____ Email _____ Cell# _____

Patient's Name _____
LAST FIRST MIDDLE

Address _____
CITY STATE ZIP CODE

Home Phone _____ Birthdate _____ Social Security# _____

Whom may we thank for referring you to our office? _____

Emergency contact _____ Relationship _____

Complete Address _____ Phone _____

RESPONSIBLE PARTY INFORMATION

Name _____
LAST FIRST MIDDLE

Residence _____
STREET CITY STATE ZIP

Mailing Address _____
STREET CITY STATE ZIP

How long at this address _____ Home Phone _____ Work Phone _____

Social Security# _____ Birthdate _____ Relationship to Patient _____

WORK INFORMATION

Employer _____ Occupation _____ #Years Employed _____

Employer Address _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ #Years Employed _____

Employer Address _____

INSURANCE INFORMATION

Insured's Name _____ Insured's Social Security# _____

Insurance Company _____ Group# _____

Insurance Co. Address _____ Phone _____

Do you have dual coverage? Yes ___ No ___ **If yes: Please complete the following secondary insurance information.**

Insured's Name _____ Insured's Social Security# _____

Insurance Co. _____ Group# _____

DENTAL INFORMATION

Do your gums bleed when you brush? Yes ___ No ___

Are your teeth sensitive to heat or cold? Yes ___ No ___ Pressure? Yes ___ No ___ Sweets? Yes ___ No ___

Do you grind or clench your teeth? Yes ___ No ___

Do you have any fear of dental work? Yes ___ No ___

Do you or have you had TMJ / jaw problems? Yes ___ No ___

If yes, please explain symptoms _____

Date of last X-Rays _____

Is your mouth dry? Yes ___ No ___

Have you had orthodontic treatement? Yes ___ No ___

Have you had periodontal / gum treatment? Yes ___ No ___

Would you like to change anything about your teeth? _____

PLEASE COMPLETE BACK PAGE

Medical Information

1. Are you having pain or discomfort at this time? ..... YES NO
2. Have you been a patient in the hospital during the past two years? ..... YES NO
3. Have you been under the care of a medical doctor during the past two years? ..... YES NO
   Physician's Name _____ Phone _____
   Address _____
4. Are you taking any medication or drugs? ..... YES NO
   If yes, please list: _____
5. Any allergies? ..... YES NO
   If yes, please list: _____

6. Indicate which of the following you have had or have at present. Circle yes or no for each item.

Heart Disease or Attack	YES	NO	Kidney Trouble	YES	NO	Hepatitis B (serum)	YES	NO
Heart Murmur	YES	NO	Ulcers	YES	NO	Venereal Disease	YES	NO
High Blood Pressure	YES	NO	Diabetes....Type 1 / Type 2	YES	NO	H.I.V. Positive	YES	NO
Arteriosclerosis	YES	NO	Thyroid Problems	YES	NO	Cold Sores/Fever Blisters	YES	NO
Mitral Valve Prolapse	YES	NO	Glaucoma	YES	NO	Blood Transfusion	YES	NO
Artificial Heart Valve	YES	NO	Cancer	YES	NO	Hemophilia	YES	NO
Heart Pacemaker	YES	NO	Emphysema	YES	NO	Anemia	YES	NO
Rheumatic Fever	YES	NO	Chronic Cough	YES	NO	Bruise Easily	YES	NO
Arthritis	YES	NO	Tuberculosis	YES	NO	Liver Disease	YES	NO
Rheumatism	YES	NO	Asthma	YES	NO	Epilepsy or Seizures	YES	NO
Cortisone Medicine	YES	NO	Hay Fever	YES	NO	Fainting or Dizzy Spells	YES	NO
Drug Use/Addiction	YES	NO	Allergies or Hives	YES	NO	Nervousness	YES	NO
Stroke	YES	NO	Sinus Trouble	YES	NO	Tumors	YES	NO
Artificial Joints (Hip, knee, etc.)	YES	NO	Hepatitis A (infectious)	YES	NO			

7. Do you have or have you had any disease, condition, or problem not listed? ..... YES NO
   If yes, please list: _____
8. Do you need to take an antibiotic before dental appointments? ..... YES NO

FOR WOMEN ONLY:
Are you pregnant? ☐Yes, what month?_____ ☐No Are you nursing? ☐Yes ☐No Are you taking birth control pills? ☐Yes ☐No

CONSENT:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated of such treatment in connection with (name of patient)_____. I understand that using anesthetic agents embodies certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1½% finance charge (18% APR) may be added to my account, in addition to any collection charge.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.
6. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

IN OFFICE ONLY

I HAVE REVIEWED IN OFFICE A COPY OF THE HIPPA PRIVACY ACT AND THE FACTS ABOUT FILLINGS BOOKLET

Patient Signature _____ Date _____

FOR OFFICE USE: Reviewed by Dr. _____ Date: _____

Dr. Casey Patterson DDS.
FINANCIAL POLICIES

THANK you for choosing us to help you and your family strive for your family's optimum oral health. Investing in quality dental care can be a step toward improved appearance and self-esteem. In order to ensure that our relationship has a positive beginning, it is important that you read and understand our office policies. Feel free to ask any questions that you may have regarding our policies.

AN appointment to visit our office reserves the time exclusively for you. Failing to keep a reserved appointment will result in a charge of $50 per half hour, at our discretion. No fees will be charged for rescheduling an appointment provided 24 hours or more notice is given.

WE respect your desire to make a responsible decision regarding your treatment and its related fees. Every effort will be made to discuss the benefits, alternative treatments, possible risks, and financial aspects of your procedure so that you may make an informed decision to either accept or refuse the recommended treatment. Acceptance of treatment implies that you understand and consent to all treatment and fees involved.

AS a courtesy we will submit your dental insurance claim and accept assignment if the information we need from you is provided in a timely manner. Your treatment will not be compromised in order to meet the usual and customary fees that your insurance company may impose. It is important for you to understand that insurance benefits generally do not cover the entire fee and that the difference will be owed by you. Dental insurance does not absolve you of the financial responsibility for treatment rendered. Our office staff will gladly be of assistance should you have any questions about your treatment or related costs.

IF you have dental insurance your patient portion is expected to be paid with either cash, check, debit card or major credit card on the day of treatment. MasterCard, Visa, DiscoverCard and CareCredit are accepted by our office for your convenience. Financial arrangements, subject to credit approval, may be made before treatment is rendered. There is a $25 handling and bookkeeping fee for any returned checks.

WHEN your balance remains unpaid after 60 days your account becomes delinquent. A late charge will accrue on the account balance at the rate of 1.5% per month (18% annually). You will also receive a letter stating that in 30 days your account will be reported to TRW and collection proceedings begun. A bookkeeping fee of $50 will be charged to your account when TRW is notified. Any fees, including court and attorney fees, will be the responsibility of the guarantor.

FAILURE to sign this agreement does not negate your financial obligation for any of your previous or future treatment.

I understand and agree to abide by the above office policies:

_____	_____	_____
SIGNATURE	DATE	RELATIONSHIP TO PATIENT

I also agree to pay for the services rendered in the following way: (please circle)

1. Cash, Check or Debit Card at the time of treatment.
2. MasterCard, Visa, DiscoverCard or CareCredit at the time of treatment.
3. I will furnish Insurance Forms/Insurance Information AND I agree to pay my portion at each visit.
4. Other_____.

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 Practices, 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)

_____

_____

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