Chart #: *«Chart»*
FOR OFFICE USE ONLY

Patient Information

Patient Name: ______________________________ Date:__________
Last, First MI (Preferred Name)
Gender: ______________ Family Status: ______________

Social Security #: ______________________________ Birth Date: ______________________________

Phone (Home): _______________ (Work): _______________ Ext:_________ (Cell): __________
Email Address: ______________________
Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F

Address: ____
Street Apartment #

____
City State Zip Code

Health Information

Reason for this visit: ____

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

- ☐ AIDS/HIV
- ☐ Allergies __________ ________________
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Diabetes
- ☐ Dizziness
- ☐ Ear Pain/Congestion
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Headaches
- ☐ Head Injuries
- ☐ Heart Concerns
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ History of cancer
- ☐ History of HPV
- ☐ Jaw Pain or Noise
- ☐ Kidney Disease
- ☐ Limited Opening
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Premedication Needed
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Smoking / Years___
- ☐ Chewing tobacco / Years ___
- ☐ Snoring
- ☐ Substance Abuse
- ☐ Tooth Clenching/Grinding
- ☐ Women; Are you Currently pregnant?
  - ☐ Due date:_____

OTHER:
☐ _________________

- Please list all current medications and dose:____

____

- Have you ever had any complications following dental treatment? ☐ 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: _________________

- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date: ____________________
Signature of patient, parent or guardian

OSHA guidelines require us to ask our source patient if they would submit to a blood test in the event that an employee would injure themselves from a sharp instrument that has been used in treatment. All precautions are taken in this office to avoid such a situation. However, in the highly unlikely event that this would occur during your treatment, may we have your permission to send you for blood testing at our expense? Yes No

Referral Information

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

☐ Dental Office ☐ Phone Book ☐ All Care Website ☐ Insurance Website ☐ 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: ______________

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 1½% per month (18% 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.

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

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

ALL CARE DENTAL

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

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

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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ALL CARE DENTAL

Acknowledgement of Receipt of HIPAA Privacy Policies and Procedures

I, ____, have received and reviewed a copy of All Care Dental's health information privacy and security policies and procedures.

Print Name____

Signature____

Date____

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