FINANCIAL AGREEMENT

* For my convenience, this office may release my information to my insurance company, and receive payment directly from them.
* I understand that if I begin restorative treatment (i.e. fillings, crowns, extractions, etc), I will be responsible for a portion or the total fee (depending on insurance coverage) at the time of treatment.
* If sent to collections, I agree to pay all related fees and court costs.
* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
* I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.
* I will pay a fee for appointments broken without 24 hours notice.
* Treatment plans may change, and I will be responsible for the work actually done.

Signature_____ Date_____

NOTICE OF PRIVACY POLICIES

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities and healthcare operations. I also understand that I have the right to revoke permission.

Signature_____ Date_____

MEDICAL HISTORY

Name of Medical Doctor:_____ City/State_____
Preferred Pharmacy:_____
Emergency Contact_____ Phone_____Relationship_____

List all the medications or drugs you are now taking:
[ ] None_____
_____
_____
_____
_____

List all the medications or drugs you are allergic to:
[ ] None_____
_____
_____
_____
_____

List any medical conditions you may have including: asthma, bleeding problems, cancer, diabetes, heart murmur, heart trouble, high blood pressure, joint replacement, kidney disease, liver disease, pregnancy, psychiatric treatment, sinus trouble, stroke, ulcers, or history of rheumatic fever.
[ ] None_____
_____
_____
_____

Tobacco use? If so, what kind and how much?_____
If female, are you [ ] Pregnant [ ] Nursing [ ] Taking birth control pills

Unusual reaction to dental injections?_____
Reason for today's visit_____ Are you in pain? _____
New patients:
Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? _____
Do you have BiteWing x-rays that are less than 1 year old?_____
Name of former dentist_____ City/State_____
Date of last cleaning and exam_____

Patient Name (Please Print):_____

Signature_____Date_____