PATIENT INFORMATION

NAME____ DATE____________________
LAST, FIRST, MIDDLE INITIAL

ADDRESS_______________________________CITY_____________STATE________ZIP__________

EMAIL_________________________ SOC. SEC #___________________________BIRTHDATE________________

HOME PHONE________________________CELL PHONE_______________________ ☐ MALE ☐ FEMALE

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ OTHER

WHOM MAY WE THANK FOR REFERRING YOU? ____

EMERGENCY CONTACT ____________________________________ PHONE_______________________

HEALTH INFORMATION

DATE OF LAST DENTAL VISIT ___________________________REASON FOR THIS VISIT___________________________

PLEASE CHECK ALL THAT APPLY:

AIDS	☐	Excessive Bleeding	☐	Liver Disease	☐	Tuberculosis	☐
Allergies:	☐	Fainting	☐	Mental Disorders	☐	Tumors	☐
____________		Glaucoma	☐	Nervous Disorders	☐	Ulcers	☐
____________		Growths	☐	Pacemaker	☐	Venereal	
Anemia	☐	Hay Fever	☐	Pregnancy	☐	Disease	☐
Arthritis	☐	Head Injuries	☐	Due: __________		Codeine Allergy	☐
Artificial Joints	☐	Heart Disease	☐	Radiation Treatment	☐	Penicillin Allergy	☐
Asthma	☐	Heart Murmur	☐	Respiratory Problems	☐	OTHER:	
Blood Disease	☐	Hepatitis	☐	Rheumatic Fever	☐	______________________	
Cancer	☐	HIV	☐	Rheumatism	☐	______________________	
Diabetes	☐	High Blood Pressure	☐	Sinus Problems	☐	______________________	
Dizziness	☐	Jaundice	☐	Stomach Problems	☐	______________________	
Epilepsy	☐	Kidney Disease	☐	Stroke	☐	______________________	

Are you currently taking any medication? Yes☐ No ☐
If yes, please list: ____

Have you ever had any complications following dental treatment? 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: __________________________

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

X____**RELATIONSHIP TO PATIENT**__________
SIGNATURE OF PATIENT OR PARENT IF MINOR

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ____

RELATIONSHIP TO PATIENT _________________________ __HOME PHONE_________________________

ADDRESS_____________________________________CITY____________STATE_______ZIP________

EMAIL______________________ SOC. SEC #_________________________BIRTHDATE______________

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? : ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED_________________________________RELATIONSHIP TO PATIENT_________________

BIRTHDATE_________________ SOC. SEC. #___________________ DATE EMPLOYED ________________

NAME OF EMPLOYER ______________________ UNION OR LOCAL #________ WORK PHONE____________

EMPLOYER ADDRESS________________________________CITY____________STATE_____ZIP_________

INSURANCE CO.___________________ TEL#______________GRP #_________ POLICY/I.D_____________

INSURANCE CO. ADDRESS___________________________CITY___________ _STATE_____ZIP__________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, PLEASE COMPLETE THE FOLLOWING:

NAME OF INSURED _______________________________ RELATIONSHIP TO PATIENT_________________

BIRTHDATE______________________ SOC. SEC #__________________ DATE EMPLOYED_____________

NAME OF EMPLOYER ______________________ UNION OR LOCAL #________ WORK PHONE____________

EMPLOYER ADDRESS________________________________CITY____________STATE_____ZIP_________

INSURANCE CO.___________________ TEL#______________GRP #_________ POLICY/I.D_____________

INSURANCE CO. ADDRESS___________________________CITY___________ _STATE_____ZIP__________

X____RELATIONSHIP TO PATIENT_________

SIGNATURE OF PATIENT OR PARENT IF MINOR

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon reimbursement from the patients for the costs I incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency 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/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 conditions 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 ½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days unless previously written 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 it credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, writing within the time for payment thereof. I further agree that a waiver of any breech 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 fee if suit be instituted hereunder.

I grant my permission to you your assignee, to telephone me at home or at work to discuss matters related to this form.

PHOTO RELEASE

I, ___________________________________, hereby authorize Port Washington Dental Care to take photograph, slides, digital image and or video of my smile, teeth, jaw and/or face for identification and treatment purposes only.

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEGEMENT

Patient Name: ____BIRTHDATE________________

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

X____RELATIONSHIP TO PATIENT____________

SIGNATURE OF PATIENT OR PARENT IF MINOR

SIGNATURE OF WITNESS ______________________________________DATE_______________________________