

PATIENT INFORMATION

NAME: _____

Address: _____ City: _____ State/Zip: _____

Home Phone: _____ Work Phone: _____ Cellular: _____

Sex: () Male () Female Martial Status: () Married () Single () Divorced () Separated () Widowed

Birth Date: _____ SS#: _____ E-Mail: _____ () I would like to receive correspondence via e-mail

Whom may we thank for referring you: _____ (Please Fill Out)

Are you under a physician's care now? O Yes ONo ON/A Explain: _____

Have you ever been hospitalized or had a major operation? O Yes ONo ON/A Explain: _____

Have you ever had a serious head or neck injury? O Yes ONo ON/A Explain: _____

Are you taking any medications, pills, or drugs? O Yes ONo ON/A Explain: _____

Do you take, or have you taken, Phen-Fen or Redux? O Yes ONo ON/A Explain: _____

Are you on a special diet? O Yes ONo ON/A Explain: _____

Do you use tobacco? O Yes ONo ON/A Explain: _____

Do you use controlled substances? O Yes ONo ON/A Explain: _____

Women: [] Are you Pregnant/Trying to get pregnant? [] Nursing? [] Taking oral contraceptives?

Are you allergic to any of the following?

[] Aspirin [] Penicillin [] Codeine [] Acrylic [] Metal [] Latex [] Local Anesthetics

[] Other If yes, explain: _____

Have you ever been told by a medical physician that you need to take an Antibiotic Pre-Medication prior to any dental treatment?

[] Yes [] No

Do you have, or have you had, any of the following?

- Alzheimer's Disease, Anemia, Arthritis/Gout, Artificial Heart Valve, Artificial Bones/Joints, Asthma, Bruise Easily, Cancer/Tumor, Chemotherapy, Chest Pains, Cold Sores/Fever Blisters, Diabetes, Drug Addiction, Emphysema, Epilepsy or Seizures, Fainting Spells/Dizziness, Frequent Headaches, Glaucoma, Heart Attack/Failure, Heart Murmur, Heart Pace Maker, Heart Trouble/Disease, Hepatitis A, Hepatitis B or C, High Blood Pressure, HIV/AIDS, Kidney Problems, Leukemia, Low Blood Pressure, Mitral Valve Prolapse, Pain in jaw, Psychiatric Problems, Rheumatic Fever, Scarlet Fever, Shingles, Sinus Trouble, Stroke, Swelling of Limbs, Tuberculosis (TB), Ulcers

Have you ever had any serious illness not listed above? () YES () NO If yes, explain: _____

*****Do you take Fosomax, Actonel, or Boniva? () YES () NO If yes, which one: _____

PAYMENT ALTERNATIVES-CHECK YOUR PREFERENCE

- 1. Payment paid in full with cash or personal check. For amounts over \$800, we offer a 5% reduction in the fee for payment in full when patient receives treatment. We gladly process any insurance claim for your direct reimbursement.
2. We accept credit cards. (Visa, MasterCard, Discover or American Express)
3. Interest free payment plans for up to 3,6 or 12 months for amounts over \$250 or over with no down payment necessary through Tower Loan. This MUST be set-up and Approved prior to work being started.
4. Pay estimated co-pay at each visit with cash, check or credit card for those patients with insurance.
5. For your convenience, your signature below authorized our office to charge your credit or debit card for any treatment performed in the office. This signature will also allow us to apply any balance after insurance has paid on your account.

Card Type: [] Visa [] MC [] Discover [] Amex Card# _____ Exp. Date _____

Responsible Party/Primary Insurance Information (If someone other than the patient)

Name of Responsible Party/Insured: _____ Relationship to Patient: () Self () Spouse () Child () Other

Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cellular: _____

Birth Date _____ Social Security: _____ () Responsible Party is a Policy Holder for Patient () Primary Ins. Policy Holder

Employer: _____ Insurance Co.: _____

Authorization:

** Note to patients with insurance:

We are happy to process any insurance Claim as a service to you at no charge. Your dental benefits program is a contract between you, your employer and the insurance company. We are not a part of the contract. Please keep in mind that any estimate that we provide is ONLY AN ESTIMATE and that you are responsible for all fees in their entirety. Due to delays with insurance companies, we ask that if your insurance has not paid your visit within 90 days, that cover your balance and seek reimbursement directly from insurance company. We are proud that our fees reflect the time that the doctor spends with each patient as well as overall quality of care and service that we provide in our practice. Our fees are not based upon any insurance schedules, and are often above insurance allowances. You may wish to complain to your company's benefits representative should your benefits be less than you expected. THIS INFORMATION IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT I'M RESPONSIBLE TO PAY FOR SERVICES RENDERED, INCLUDING REASONABLE ATTORNEY'S FEES AND COST OF COLLECTION IN THE EVENT OF DEFAULT.

Signature of Responsible Party

Date