

Physician's Name _____ Physician exam _____

In the event of an emergency, who should we contact?

Name _____ Relationship _____ Phone # _____

- | | Yes | No |
|---|--------------------------|--------------------------|
| Do you ever experience shortness of breath or pain in the chest after climbing stairs or other exertion?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Do your ankles swell during the day? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you lost or gained more than 10 pounds in the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any disease, condition, or problem not listed? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you using oral contraceptive medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are there now any unhealed injuries or irritated areas in or around your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do your gums ever bleed? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have pain in your ears? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you clench your teeth during the day or night? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you experience frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a reaction to anesthetic (novocaine)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you smoke or use tobacco in any other form? | <input type="checkbox"/> | <input type="checkbox"/> |

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGE IN MY HEALTH, OR IF MY MEDICINE CHANGES, I WILL INFORM THE DOCTOR IMMEDIATELY.

Signature (parent or guardian if under 18 years old) _____

INSURANCE INFORMATION

Insured's Name _____ Employer _____

Occupation _____ Birthdate _____

Dental Insurance Co. _____ Group # _____

Insured's S.S. # _____

Insured's Name (if dual coverage) _____ Birthdate _____

Employer _____ Dental Ins. Co. _____

Group # _____ Soc. Sec. # _____

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish our patients to know that all professional services rendered are charged Directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your Benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies Will pay our fees.

Financial Arrangements

For your convenience we offer the following methods of payment. Please check the option which you prefer below:

- Cash I wish to discuss the dental office policy.
- Personal Check
- Credit Card #

Authorization, Release, and Agreement to Pay For Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payors and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits Otherwise payable to me.

I authorize and hereby request my insurance carrier may pay less than the actual bill for services. I agree to be responsible for Payment of all services rendered on my behalf or on behalf of my dependents.

X

Signature of patient or parent if minor _____
Date

APPOINTMENTS: A minimum charge of \$25.00 will be made for failed
Or cancelled appointments without prior notification of 48 hours.

Balances not paid within 90 days of the billing date, will be assessed at 1.5% each month until paid in full.

{NAME OF PRACTICE}

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)

UNIVERSITY DENTAL ASSOC., P.C.
FINANCIAL POLICY

- *Payment is due at the time of service. If you have insurance, your estimated co-pay is due at the time of service.*
- *The following methods of payment are accepted: Cash, Check, Visa, MasterCard, and Discover & American Express.*
- *A service charge for all returned checks will be assessed.*
- *Care Credit payment plan is available with "interest free" options.*
- *A statement of financial responsibility is necessary for minor patients of divorced parents. This will help the practice avoid getting caught in the middle and/or having to collect from a parent whom we have never met.*
- *New patient emergency visits must be paid in full at the time of service.*

INSURANCE ASSIGNMENT AND MANAGEMENT

- *Patients must provide the office with accurate insurance billing information at the time of their appointment, or they are responsible for payment in full.*
- *Insurance benefits are a contract between the patient and his/her employer.*
- *The coverage a patient will receive depends upon the quality of the plan purchased by his/her employer, not the fees of the doctor.*
- *Patients are responsible for paying their deductibles and co-payments at the time of service. Patients are also responsible for paying all charges not covered by their insurance plans, including all fees considered above their insurance policy's usual and customary fee schedule.*
- *The office will submit a claim up to two (2) times per appointment; further insurance appeal becomes the patient's responsibility.*
- *The office will accept assignment (payment) from the primary and secondary insurance coverage.*

PLEASE REMEMBER... Your insurance policy is between you and your insurance company; not between your insurance company and your doctor. It is your responsibility to know your individual coverage. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred during your office visit.

Sign _____
Date _____