Consent for Service

As a condition of your treatment by this office, financial arrangement must be made in advance. The practice depends upon reimbursement from the patient for the cost 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 service performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patient's who carry a 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 insurance forms or assist in making collections form 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 charged will be paid by all insurance companies.

A service charge of 1 1/2% per month (18% annum) on the unpaid balance will be charged on all account 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 6 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 that time of payment thereof. I further agree that a waiver of breach of any time or condition hereunder shall not constitute a waver of any further term or condition and I further agree to pay all cost and reasonable attorney fees if suit be instituted hereunder.

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

I have read the above conditions of treatment and payment and agree to their content.

_____ _____

Signature of patient, parent, or legal guardian **Date**

Team and Patient Commitment

Our team commitment is to provide every patient with the highest quality care if dentistry at the most reasonable cost. We make every effort to be respectful of your time.

Patient appointments are scheduled with specific amounts of time so that we can provide you with undivided attention and be on time for your reserved appointment and for appointments scheduled with following patients.

We ask that you honor your reservation with us, commit to your appointment, be on time and in the event you need to reschedule your appointment, we ask that you provide us with at least 24-hours notice. An appointment is considered broken if canceled on the same day of the appointment, no matter the reason. After two broken appointments within a year's time period, we elect to no longer pre-appoint you. We will be able to treat you on a "walk-in basis" only. Cancellations must be made by speaking directly to a team member and will not be accepted via voicemail or text message.

I have read and understand and will honor the team and patient commitment.

_____ _____

Signature of patient, parent, or legal guardian **Date**

Health History

Primary Care Physician: _____ **Phone Number:** _____

Are you currently pregnant, nursing, or trying to become pregnant? If yes, please provide name and phone number of your OB-GYN.

_____

Do you currently take any type of anticoagulants (blood thinners)?

_____

Have you been admitted to the hospital or needed emergency care during the past two years? If yes, please explain.

_____

Are there any medical conditions that we should be made aware of prior to your dental treatment?

_____

Please check if you are currently having or have had any of the following:

__ HIV/AIDS	__Epilepsy	__Liver Disease	__Tumors
__Alzheimer's Disease	__Fainting	__Mental Disorders	__Ulcers
__Anaphylaxis	__Glaucoma	__Nervous Disorders	__Venereal Disease
__Anemia	__Hay Fever	__Pacemaker	__Codeine Allergy
__Arthritis/Gout	__Head Injuries	__Pregnant	__Penicillin Allergy
__Artificial Joint	__Heart Disease	__Respiratory Problems	__Other:
__Asthma	__Heart Murmur	__Rheumatic Fever	
__Blood Disorder	__Hepatitis	__Sinus Problems	
__Cancer	__High Blood Pressure	__Stomach Problems	
__Chemotherapy/Radiation	__Jaundice	__Stroke	

Medication List

Name: MG: Dosage:

_____

_____

_____

_____

_____

_____

_____

YOUR COMMUNITY
DENTAL

Patient Information

Patient Name:_____ Preferred Name:_____

Date of Birth:_____ Gender: Male Female

Social Security Number:_____ Marital Status: Married Single Widowed Other:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone (Home):_____ Phone (Mobile): _____

Email Address:_____

Emergency Contact:_____ Relationship to Patient:_____

Emergency Phone:_____

Referral Source: Website TV Insurance Family/Friend Other:_____

Insurance Information

Insured Name: _____ Relationship to Patient: _____

Insured Date of Birth: _____ Insured SSN: _____

Employer:_____ Work Phone : _____

Insurance Company: _____

Policy ID:_____ Group Number:_____

Insurance Mailing Address:_____

Insurance Phone Number: _____

Notice of Privacy Practice

Summary: By law, we are required to provide you with our Notice of Privacy Practice (NPP). This notice describes how your medical and dental health information may be used and disclosed by our office. It also informs you of how your may obtain this information.

I hereby acknowledge that I have reviewed the practice's Notice of Privacy Practice. I further understand that if the Notice of Privacy Practice should change in any way, the practice will offer me a revised copy to review. By signing this form you agree to the above.

Please list everyone you authorize health and treatment information to be released

Name:_____ Relationship to Patient: _____

Name:_____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Signature:_____ **Date:**_____