Patient Information Form

FOR OFFICE USE ONLY

Doctor #_____
Patient #_____
_____

Downtown DENTAL ASSOCIATES

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Last Name_____ First Name_____ Initial_____ Date_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____ Email_____

SSN_____ Birth Date_____

Check boxes that apply to you: ☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Patient's (or Parent's) Employer_____ Dept._____ Phone/Ext._____ Years of Employment____

Spouse (or Parent's) Name_____ Employer_____ Work Phone_____

If you are a student, name of School/College_____ City_____ State_____

In case of emergency, we should call_____ Phone_____ Relation to Patient_____

Which Doctor do you wish to see_____ How did you come to be our patient_____

Financial Information

Name of person responsible for paying this account_____ Relationship to you_____

Address_____ City_____ State_____ Zip_____ Phone_____

Social Security Number_____ Birth Date_____

Employer_____ Phone_____ Is this person a current patient of ours ☐ Yes ☐ No

We offer the following ways to pay your bill in full at each appointment. Check your preference: ☐ Cash ☐ Check ☐ Credit Card

Dental Insurance Information

Primary Insurance Company_____ Group #_____ Employee/Certificate #_____

Insurance Company Address_____ City_____ State_____ Zip_____

Insured Person_____ Relationship to you_____ Insured's Birth Date_____

Insured's Employer_____ Phone_____ Insured's SSN_____

Dental History

Date of last dental visit_____ Purpose of today's visit_____

1. Do your gums bleed when you brush or floss? ☐ Yes ☐ No
2. Are your teeth sensitive to hot or cold foods or liquids? ☐ Yes ☐ No
3. Are your teeth sensitive to sweet or sour foods or liquids? ☐ Yes ☐ No
4. Do you feel pain in any of your teeth? ☐ Yes ☐ No
5. Do you have any sores or lumps in or near your mouth? ☐ Yes ☐ No
6. Have you had any head, neck or jaw injuries? ☐ Yes ☐ No
7. Have you ever had any of the following problems with your jaw?
   - Clicking ☐ Yes ☐ No
   - Pain in joint, ear or side of face ☐ Yes ☐ No
   - Difficulty in opening or closing ☐ Yes ☐ No
   - Difficulty in chewing ☐ Yes ☐ No
8. Do you have frequent headaches? ☐ Yes ☐ No
9. Do you clench or grind your teeth? ☐ Yes ☐ No
10. Have you had any difficult extractions? ☐ Yes ☐ No
11. Have you had any orthodontic work? ☐ Yes ☐ No
12. Have you had prolonged bleeding after an extraction? ☐ Yes ☐ No
13. Have you been taught how to brush your teeth correctly? ☐ Yes ☐ No
14. Have you ever been advised on how to care for your gums? ☐ Yes ☐ No

Medical History

Physician _____ Office Phone _____

Date of last exam _____

1. Are you under medical treatment? ☐ Yes ☐ No

2. Have you ever been hospitalized for surgery or serious illness?
   ☐ Yes, for: _____
   _____ ☐ No

3. Are you taking any medications?
   ☐ Yes, which medicines _____
   _____
   _____
   _____ ☐ No

4. Do you use tobacco products? ☐ Yes ☐ No

5. Are you allergic to or have any reactions to the following?

Local anesthetics like Novocain	☐ Yes	☐ No
Penicillin	☐ Yes	☐ No
Erythromycin	☐ Yes	☐ No
Codeine	☐ Yes	☐ No
Aspirin	☐ Yes	☐ No
Any others not listed	☐ Yes	☐ No

Please specify: _____

6. For female patients:

Are you pregnant or think you may be?	☐ Yes	☐ No
Are you taking birth control pills?	☐ Yes	☐ No

7. Do you have or have you had any of the following?

High blood pressure	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No
Rheumatic fever	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Leukemia	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Low blood pressure	☐ Yes	☐ No
Epilepsy or convulsions	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No
Cardiac pacemaker	☐ Yes	☐ No
Kidney diseases	☐ Yes	☐ No
AIDS or HIV infection	☐ Yes	☐ No
Thyroid problem	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No
Angina	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Stomach troubles or ulcers	☐ Yes	☐ No
Hepatitis or Jaundice	☐ Yes	☐ No
Sexually transmitted disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Joint replacement or implant	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Hay fever or other allergies	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Radiation therapy	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Liver disease	☐ Yes	☐ No
Heart trouble	☐ Yes	☐ No
Respiratory problems	☐ Yes	☐ No
Anything else	☐ Yes	☐ No

_____

_____

Authorization and Release

We will be glad to file your Insurance Claims at no charge, but any disputes on claims are between you and your insurer.

I authorize Downtown Dental Associates to release any information including the diagnosis and the records of any treatment or examines rendered to me or my child during the period of such dental care to third party payers and/or other heath practitioners.
I authorize and request my insurance company to pay directly to the dentist or dental group any insurance benefits otherwise payable to.
I understand that my dental insurance carrier may pay an amount less than the actual bill for services.
I agree to be held responsible for payment of all services rendered on behalf of me or my dependents.
I certify that I have read and understood the information on this form. I have answered all questions truthfully to the best of my knowledge.
I understand that providing incorrect information can be detrimental to my health.
I understand that in the event I do not pay my bill that is owed to Downtown Dental Associates I agree and will pay and all reasonable collection and/or attorney's fees involved in the recovery of monies due to Downtown Dental Associates.

I acknowledge Patients Rights and Privacy Practice Act has been made available to me.

Signature of patient, parent or guardian: _____ Date _____

Financial Policy

GENERAL

Thank you for choosing our practice as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read, and sign prior to treatment. All patients must complete our information and insurance form before seeing the doctors. FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECK, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS AND CARE CREDIT.

DOWNTOWN DENTAL ASSOCIATES IS NOT RESPONSIBLE FOR WHAT SERVICES YOUR INDIVIDUAL INSURANCE CARRIER WILL OR WILL NOT COVER

INSURANCE

Fees are estimates only, are valid for 90 days from the date shown and are subject to revision. Treatment could be altered if your dental needs change. The patient will be notified of any change(s) in treatment. All ESTIMATED portion and deductibles are due prior to treatment. In the event that YOUR insurance coverage changes to a plan where we are non-participating providers, refer to above paragraph.

USUAL AND CUSTOMARY RATES

Our practice is committed in providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

ADULT PATIENTS

Adult patients are responsible for full payment at time of service.

MINOR PATIENTS

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For Unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to be approved; Visa/MasterCard/American Express, or payment by cash or check at time of service has been verified.

MISSED APPOINTMENTS

Unless cancelled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $80. Please help us serve you better by keeping scheduled appointments.

INTEREST

We reserve the right to charge interest in the amount of 18% per annum as provided by state law.

_____ _____

Signature Relationship to patient

_____

Date