Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date_____
Last, First MI (Preferred Name)

Marital Status _____Gender: _____

Social Security #: _____ Birth Date: _____

Email: _____

Phone (Home): _____ (Cell):_____ (Work):_____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit:_____ Reason for this visit: _____

Have your ever had any of the following? Please check those that apply:

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

OTHER:

- ☐ _____
- ☐ _____

• 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: _____

• Name of Physician: _____ Phone: _____

• Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

Please list medications you are currently taking _____

_____

_____

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

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient ☐ Dental Office ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Insurance Plan Name and Address: _____

_____

Insurance Plan Phone Number: _____

Who is the subscriber?: _____ Is subscriber a patient? ☐ Yes ☐ No
Last First MI

Subscriber's Birth Date: _____ ID #: _____ Group #: _____

Subscriber's Address: _____
Street City State Zip Code

Subscriber's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary

Insurance Plan Name and Address: _____

_____

Insurance Plan Phone Number: _____

Name of subscriber: _____ Is subscriber a patient? ☐ Yes ☐ No
Last First MI

Subscriber's Birth Date: _____ ID #: _____ Group #: _____

Subscriber's Address: _____
Street City State Zip Code

Subscriber's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Cancellation Policy

We ask for at least 2 Business days advance notice for canceling or rescheduling an appointment; otherwise a $50 per hour fee may be assessed to your account.

Note: All Cancellation fees must be paid prior to scheduling another appointment.

The treatment that is planned for you is specific to you. It is important for you to keep the scheduled date and time to properly complete the treatment.

A broken appointment is a loss to three people –

- The patient who missed the valuable time
- Another patient who could have taken the valuable time
- The doctor who was fully staffed and prepared for the appointment

Here at UDistrict Smiles we strive to give the best quality care to our patients. By your keeping the scheduled appointments you enable us to better serve you.

_____

Signed by Patient

_____

Date

Financial Policy

____ Insurance

The patient or responsible party (if under 18 years old) will be responsible for paying any deductible and estimated co-pay on the day of treatment.

As a courtesy to our patients, we will submit your treatment to your insurance carrier. We will **estimate** your portion of treatment based on your dental benefit breakdown, and we will make every effort to come as close as possible to your actual co-pay. We must emphasize this is only an **estimate** and all charges you incur are your responsibility regardless of dental insurance.

We provide insurance benefit breakdowns as a courtesy to our patients; however it is your responsibility, as the patient, to maintain a good relationship with your insurance carrier. Having a clear understanding of your dental benefits (provided by your employer or insurance company) will ensure you're aware of your out of pocket expenses.

____ Patients without Insurance

All expenses are due the day of treatment. We offer two options for payment:

- A financial courtesy of 5% is offered if patients pay in full at the time of treatment. Payment must be in the form of cash or check. Payment in the form of credit card is not a part of this courtesy.
- We offer Care Credit, a healthcare line of credit. You may apply in office, online, or by phone. Your social security number is required to be on file if you are approved.

____ Outstanding Balances

Please be advised there will be a 1.5% monthly late fee to accounts with a balance due after 30 days. Statements are mailed once insurance pays their portion. Once your account reaches 100 days past due, we reserve the right to begin the collections process. A 35% processing fee will be added to your overdue account when in collections.

____ Emergency Appointments

Patients being seen on an emergency basis will be required to pay in full the day services are rendered. We will submit treatment to insurance if it is applicable. All other policies will apply.

YOUR DEDUCTIBLE AND ESTIMATED OUT OF POCKET EXPENSESARE DUE THE DAY OF TREATMENT. I understand any treatment completed will be submitted to insurance, if applicable, and any balance remaining is my responsibility as the patient. In the unlikely event I default on this agreement and a collection agency becomes involved, I understand I am responsible for any collection costs incurred in addition to my outstanding balance.

Signature of patient or responsible party _____ Date_____

Printed name of signer_____

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PATIENT RECORDS REQUEST

Name of Patient Whose Record is Requested _____

DOB _____Phone_____

Address_____City/State/Zip_____

Please provide a copy of the record as indicated below:

- The full health record maintained by this provider/practice
- The health record for the following time frame:_____through_____
- A specific section of the health record as described below:

_____

Previous dentist information:

Name: _____ Phone: _____

Address: _____ City/State/Zip_____

Email address:_____

Signature of Patient _____ date_____

Signature of Authorized Personal Representative _____

Relationship to Patient _____