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Patient Information and Consent Form

Date: _____

Patient Name: _____ Preferred Name: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ Birth Date: ___/___/____ Driver's State & Number ____ _____

Phone (Home): _____ (Cell): _____ (Work) _____ext._____
Text message Accepted? Yes or No

E-Mail Address_____ Email message Accepted? Yes or No

Address: _____
Street Apartment #

_____
City State Zip Code

Responsible Party

Name: _____
☐ Male ☐ Female ☐ Self ☐ Spouse ☐ Other _____

Social Security #: _____ Birth Date: ___/___/_____ Driver's License State: ___ No. _____

Phone (Home): _____ (Work): _____ Ext: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employer Name: _____ Phone Number: _____ Ext._____
Employer Address: _____
Street City State Zip Code

Insurance Information

Primary Policy Holder: _____
Last First MI

Birth Date: _____ SS#: _____

Insurance Plan Name: _____ Insurance Phone Number: _____

Subscriber ID #: _____ Group #:_____

Employer Name: _____Phone Number: _____ Ext _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Referral Information

How did you hear about our office?

☐ Street Sign ☐ Sign on Building ☐ Internet Site: _____

☐ Flyer in Mail ☐ Other:_____

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

Health History Information

Patient Name_____ Date _____
Reason for today's visit: _____ Date of Last Dental Cleaning Visit: _____

What would you like to improve about your smile?_____

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

- ☐ Acid Reflux
- ☐ AIDS/HIV
- ☐ Allergy - Codeine
- ☐ Allergy - Penicillin
- ☐ Allergy - Other
  - Type: _____
  - Type: _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
  - Type: _____
  - Date: _____
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer: Type: _____
- ☐ Dental Anxiety
- ☐ Diabetes Type 1 or 2
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Headaches/Migraines
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis Type____
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Recreational Drugs
  - ☐ Marijuana
  - ☐ Other_____
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ S.T.D: Type: _____
- ☐ Stroke
- ☐ Tobacco - Smoke
- ☐ Tobacco - Snuff
- ☐ Teeth Grinding/ Clench
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcer

OTHER:

- ☐ _____
- ☐ _____

PRE-MEDICATION REQUIRED? ☐ Yes ☐ No Reason: _____ Prescription: _____

****WOMEN ONLY**: Are you pregnant? Yes____ No ____ If yes, Due Date: _____

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

_____

- List of Current Medications**:**

_____
_____

- 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:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Physician: _____ Phone:_____

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.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during such Dental care to the third party and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental 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 my dependents.

X_____ Date: _____/_____/_____ Relationship to Patient: _____
Signature of patient or legal guardian

Office Policy/Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

INSURANCE

Our office files insurance only as a courtesy to our patients. We will initially ask you only for your estimated co-payment but please understand that this is **ONLY AN ESTIMATE** based upon the information available to us. Therefore, the patient/primary policy holder is responsible for any unpaid balances.

CANCELLATION POLICY

We appreciate you as a patient and have reserved this valuable time just for you. In order to serve our patients better we cannot accommodate last minute schedule changes. It does not allow us time to offer that appointment to another patient. If you are unable to keep an appointment, we ask that you kindly provide us with at least 24 hours notice.

Missed appointments without 48 hour notice will charged a $40.00 cancellation fee.

****Please remember that other patients may have desired the time you had reserved****

PAYMENT OPTIONS

Our office accepts checks, all major credit cards (Visa, Master Card, American Express and Discover). We also offer no interest lines of credit through Care Credit or Chase Health Advance. Please be aware that unless arrangements are made in advance, **payment is due at time of service**. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. **I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination**.

****Returned Checks will be charged a $25.00 return check fee****

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to Forest Lake Dental or any of its employees to use telephone, email, letters, text messages or any other electronic forms of communication to discuss this statement, appointment information, or my dental treatment.

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

_____ Date: _____

Signature of patient or legal guardian

Forest Lake Dental

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address: _____
_____
_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____
Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason: _____
- ❑ Other:_____
  _____

Prepared By _____

Signature _____

Date _____