Affinity Dental Associates

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PATIENT INFORMATION

Name: _____ (Nickname) _____
First Middle Last
Address:_____Apt:_____City:_____ State:___ Zip:_____

Date of Birth: _____Social Security #: _____Employer: _____

Gender: Male Female Married Single

Home: _____ Work: _____Cell: _____

Email Address: _____ Drivers License #: _____

Emergency Contact: _____Home # _____Work/Cell#_____

PERSON RESPONSIBLE FOR PAYMENT

Name: _____Date of Birth _____ Home #_____ Cell#_____
Last First
SSN:_____ Relationship:_____ Email Address: _____

Address:_____City/State/Zip:_____

Who May We Thank for referring you to our office? _____

INSURANCE SUBSCRIBER INFORMATION

1. OUR OFFICE WILL NEED A COPY OF YOUR DENTAL INSURANCE CARD/S TO PROCESS CLAIMS.

Name_____HomeTel:_____
Last First M

Address:_____WorkTel:_____

City/State/Zip:_____ Email Address:_____
SSN:_____DOB:_____ Gender: Male Female Self Spouse
Relationship to Patient:_____ Employer Subscriber:_____
Employer Tel #:_____City/State/Zip:_____

PRIMARY DENTAL NSURANCE COMPANY

1. Name of Ins Company: _____
Id#: _____ Group # _____
Company Address _____ City/State/Zip_____
Tel Number_____ Fax Number_____

If you are enrolled in an insurance plan that we accept, you are responsible to pay any deductible and co-pay due AT THE TIME OF SERVICE. The fees quoted to you are an ***estimate*** and not a guarantee of payment from the insurance company. Therefore, you are ultimately responsible for the entire balance. For those insurance plans *we participate with,* we accept their "allowed fee" by contract. For those insurance plans *we do not participate with we are not obligated to accept their allowed fee, y*ou are responsible for payment in full for what insurance will not cover.

DENTAL HISTORY

What is the Primary Reason for this dental appointment: __Examination; __Emergency; __Consultation;
Do you have a specific dental problem? Please describe: _____
Do you like your smile? Why or why not? _____
Do your gums ever bleed? _____Does food catch between your teeth? _____
Do you have any loose teeth? _____Do you grind (brux) your teeth? _____
Do you ever have clicking, popping or discomfort in the jaw (TMJ) joint? _____
Have you ever had any negative experiences at the Dentist's? _____
What is the name of your previous Dentist? _____
Date of Last: Full Mouth Radiographs (x-rays)?_____ Bitewings?_____

MEDICAL HISTORY

When did you last see your Medical Doctor?_____Why? _____
Medical Doctor's Name and number: _____
Have you ever had any hospitalizations or major operations? yes / no, Discuss: _____
Have you ever had a serious injury to your head or neck? yes / no, Discuss_____
Are you taking any prescription medications, herbal supplements, over the counter drugs, if so please list them:
_____
Do you have any allergies? Please list:_____
For women, are you: __ Pregnant or Trying; __ Nursing; __ Taking Contraceptives ___ None*
** Antibiotics interfere with contraceptives.*
Do you have or have you ever had any of the following?

Emphysema ___
Thyroid Condition ___
Kidney Problems ___
Swelling in Mouth ___
Hay Fever ___
Sinus Problems ___
Chemotherapy ___
Heart Surgery ___
Artificial Joint ___
Swelling of Limbs ___
Painful Teeth or Gums ___
Loose Teeth ___
Rheumatic/Scarlet Fever ___
Sexually Transmitted Disease __

Glaucoma ___
Stroke ___
Diabetes ___
Cancer ___
Convulsions ___
Fainting ___
Dizziness ___
Cold Sores ___
HIV / AIDS ___
Allergies ___
Hepatitis ___
Bleeding Gums ___
Arthritis ___
Heart Murmur _____

High Blood Pressure ___
Shortness of Breath ___
Angina or Chest Pains ___
Sickle Cell ___
Epilepsy ___
Persistent Fever ___
Heart Attack or Failure ___
Irregular Heart Beat ___
Tuberculosis ___
Rheumatism ___
Rash or Hives ___
Asthma ___
Congenital Heart Disease __

Other ___ Explain:
_____
_____
_____

AUTHORIZATION AND RELEASE OF RECORDS

I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental /medical histories are correct to the best of my knowledge. 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 payers and/or other health professionals.

X_____ Date_____

Patient or Responsible Party

Thank you for choosing us as your dental practice, we look forward to helping you achieve the smile you want and the oral health you deserve. Our financial policies are in writing so that you can better understand them. Please review and sign below acknowledging that you have reviewed and agreed to this policy. If you have any questions, please contact the Office Manager. **Please read carefully and sign below.**

Payment Methods: ***Payment is due at time of service****. We accept the following methods of payment.*

1. Cash, Debit Card , Money Order, Certified Check, Personal Check
2. Credit Cards – Visa, Master Card, American Express and Discover
3. You may finance with third party financing through our various financing partners: CareCredit

Finance Charges*:* Any account balance carried over 60 days will be subject to a late fee. In the event the account is turned over to a collection agency the patient will be responsible for any collection fees incurred.

Senior citizen discounts apply to patients over age 65 without insurance. As for minor patients, the parent, guardian or adult accompanying a minor is responsible for full payment, their deductible, or co-pay AT THE TIME OF SERVICE**.**

I understand and agree to this financial policy.

_____ _____

Signature of patient or responsible party Date

Cancellation Policy:

The definition of a broken appointment is as follows: calling and cancelling an appointment less than **48 business hours** of the appointment time or not showing up at all for a scheduled appointment.

The policy states all broken:

1. Cleaning, exam, x-ray, consultation, and orthodontic appointments $50.00
2. Scalings, which takes 90 minutes $100.00
3. Procedure appointments general and specialty doctors $100.00 per hour

If you need to cancel or reschedule an appointment, we require **48 business hours** notice or the above policy applies. You may leave a message on our voicemail after business hours. If you need to cancel or reschedule with less than **48 business hours notice**, you must pay all missed appointment fees prior to scheduling any appointment.

Signature _____ Date _____

I have read/understand the Notice of Privacy Practice. Signature: _____
Copy available upon request

Please be advised: Confirmation calls are a courtesy (Please do not depend on this call for a reminder***)**

_____ **Initials**