Clay Center Family Dental Care, LLC

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Patient/Responsible Party Information

Patient Name: _____ Date:_____
Last First MI

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

Social Security #: _____ Birth Date:_____ Driver's License #_____,exp date____

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

Address: _____
Street E-Mail Address

_____
City State Zip Code

Spouse Name or Responsible Party for a Minor:_____DOB:_____

Social Security #_____ Driver's License#_____

Phone & Address (if different from above)_____

_____

Health Information

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

- ☐ AIDS, HIV +/or ARC
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Fearful or anxious
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Condition
- ☐ Heart Surgery
- ☐ Heart Murmur
- ☐ Heart Valve Replacement
- ☐ Hepatitis -- Type:_____
- ☐ High/Low Blood Press
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Metal Allergies
- ☐ Migraine Headaches
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
  Year placed_____
- ☐ Currently pregnant
  Due date:_____
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tobacco use
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Adverse reaction to dental anesthetics

☐ Abnormal bleeding associated with extractions

☐ Medication allergies?
Please list
_____
_____

☐ Been advised to take antibiotics prior to dental treatment for preventive reasons?

☐ Complications following dental treatment?

Please list **all** drugs (prescription; OTC and herbal) you are taking:
_____
_____
_____
_____

Are you happy with the appearance of your smile?
Yes_____ No_____

Do you wish your teeth were whiter?
Yes_____ No _____

Name of former dentist:
_____
Date last seen:
_____

Name, Address & Phone Numbers of a friend or a relative (other than your spouse) who we may contact in case we are unable to locate you
_____
_____
_____
_____

- Are you now under the care of a physician for an on-going or chronic health problem? ☐ Yes ☐ No
  If yes, please explain _____
- Name of Physician:_____ Phone: _____

To the best of my knowledge, all of the preceding information is true and correct. If I ever have any changes in my medical or health status, I promise to notify the doctors at my next appointment.

▶ _____
Signature of patient, parent or guardian Date:

Whom may we thank for referring you to our practice? ☐ A patient ☐ A dentist or physician ☐ Radio
☐ Employee of this office ☐ Yellow Pages ☐ Newspaper ☐ Smile Cards
Name of person or office referring you to our practice:_____

Insurance Information

Primary

Name of Insured: _____ Address _____
Last First MI Street City St Zip

Phone (Home): _____ (Work):_____ Ext:_____ Relationship to Patient_____

Social Security #_____Insurance ID#_____ Birth Date: _____

Employer Name, Address & Phone: _____

Insurance Plan Name Address: _____

Phone_____

Group # _____

Secondary

Name of Insured:_____Address _____
Last First MI Street City St Zip

Phone (Home): _____ (Work):_____ Ext:_____ Relationship to Patient_____

Social Security #_____Insurance ID#_____ Birth Date: _____

Employer Name, Address & Phone: _____

Insurance Plan Name Address/Phone_____

_____Group # _____

Consent for Services & Financial Information – PLEASE READ CAREFULLY

Self-Pay Patients: Payments can be made by cash, check, credit, debit card or third-party financing (ask for information). Payment is due in full at the time of service.

BCBS & Delta Insurance Patients: *As a courtesy, this office will prepare and submit your insurance forms. All dental services are ultimately your responsibility and by signing this form you agree to pay all co-pays and deductibles ON THE DAY OF SERVICE.* You may pay with cash, check or credit card. If there is any balance not paid by your benefit company within 30 days of submission you are responsible for balance. **It is YOUR responsibility to know the parameters of your policy.**

A service charge of 1½ % per month (18% per annum) on unpaid balance will be charged to my account if my balance due is not paid within 30 days of billing. One billing statement will be sent at no charge and subsequent statements will incur a fee of $5.00.

Any fee estimates or insurance pre-determinations are valid for 60 days from the issue date.

Appointments and Appointment Changes

A great deal of work and planning is done for your appointment. Therefore, changes and cancellations to our schedule without adequate notice are catastrophic.

For this reason, we ask that any changes to your appointments be made **AT LEAST 48 HOURS** prior to your scheduled appointment. Please TELEPHONE our office for appointment changes.

If we are not notified 48 HOURS PRIOR to your appointment we regrettably may charge your account. There may be times we will have to change your appointment and we promise to give you adequate notice.

Notice of Privacy Practices as required by HIPPA

We may use your health information for two primary purposes: Treatment and payment.

TREATMENT: We may disclose your health information to another dentist or physician providing treatment to you.

PAYMENT: We may disclose your health information to obtain payment for services we provide to you (e.g. insurance company)

OTHER: It is unlikely, but we may be asked to disclose your health information as required by law for disaster relief; to report abuse or neglect; for public health statistics; by court order; to law enforcement agencies; to coroners; medical examiners; organ procurement organizations; to avert a serious threat to health or safety; to federal officials for national security and as authorized by state worker's compensation laws.

Patient Rights

ACCESS: You have the right to look at or get copies of your health information with certain reasonable restrictions.

DISCLOSURE ACCOUNTING: You have the right to know when we have disclosed your health information for any purpose other than treatment and/or payment.

I have read the above conditions of treatment, payment and appointments, and agree to their content and I hereby give my consent for treatment for me or for the above-named patient.

►_____

Signature of patient, parent or guardian or responsible party *Date* *Relationship to Patient*