



Patient Information

Name _____ Date: _____
Male _____ Female _____
Address _____
City _____ State _____ Zip _____
Phone Home# _____ Work# _____ Cell# _____
Birth Date _____ Age _____ SSN# _____
Drivers License# _____ Email _____
Employer _____ Employer Phone# _____
Employer Address _____

How did you find out about us? (If you were referred, please give the individuals name)

Spouse/Parent/ and/or Nearest Relative Information
(If any information is the same, please indicate)

Name _____ Birth Date _____
Address _____
Phone # _____ SSN# _____
Drivers License# _____
Employer _____ Employer Phone# _____

Insurance Information

Primary Carrier	Secondary Carrier
Name of Insured _____	Name of Insured _____
SSN# _____	SSN# _____
Insurance Name _____	Insurance Name _____
Employer _____	Employer _____
Group/Plan # _____	Group/Plan # _____

Please complete the reverse side of this page



Medical Information

Please check any of the following that may apply:

<input type="checkbox"/> Allergies	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Latex Allergy	<input type="checkbox"/> Seizures
<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Mental Disorders	<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> Asthma	<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Heart Disorders	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Blood Diseases	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Penicillin Allergy	<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Psychiatric Disorder	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Cold Sores	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Other
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hip/Joint Replacement	<input type="checkbox"/> Respiratory Disease	
<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Rheumatism	

If you checked "other" above, please explain: _____

Do you use any form of tobacco? _____ What Form? _____

Are you in good health? _____ If no, please explain _____

Date of last medical exam _____ Physician's Name _____

Are you currently under a physician's Care? _____ Physician's Phone# _____

Have you ever been hospitalized? _____ If so, why? _____

Do you have any other disease, problem or condition that you think I should know about? _____

Are you sensitive or allergic to any drugs or medications? _____ Please List: _____

Are you currently taking any drugs or medications? _____ Please List: _____

For Women Only

Are you pregnant? _____ If so, when is your due date? _____

Physician's Name _____ Physicians Phone# _____

Physician's Address: _____

Dental History

What is the main reason for your visit today? _____

How long since you have been to the dentist? _____

Have you ever been treated for periodontal disease? _____

Have you ever had any complications from routine dental treatment? _____

If so, please explain _____

Do you grind or clench your teeth? _____ Do your gums bleed when you brush? _____

Do you have any sores, blisters, or swelling on your gums, lips or cheeks? _____

Have you ever had orthodontic treatment? _____

Are you happy with your smile? _____

Is there any additional medical or dental information we may need to know about you before beginning treatment? _____

Consent

Minor: I being the parent or guardian of the above named minor patient, do hereby authorize the performance of dental services upon this patients and whatsoever procedures the judgment of the doctor may dictate in order to carry out treatment procedures as outlined in the treatment plan form, I also authorize and request the administration of such anesthetics and/or sedatives as may be deemed advisable by the doctor. I understand if I am not present at time of service I am authorizing the doctor to perform dental services deemed necessary at time of service.

Adult: I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or x-rays, as may be deemed necessary by the doctor.

I understand that my dental care insurance carrier or payer of my dental benefits may allow less than the actual bill for services. I understand I am financially responsible for payment in full of all accounts. By signing this statement, I agree to be responsible for all payments of services not paid in whole or in part, by my dental care payer. I also authorize dental insurance benefits to this office. I attest to the accuracy of the information on this page.

Signature: _____ Print: _____ Date: _____



FINANCIAL AGREEMENT- PAYMENT IS REQUIRED FOR ALL DENTAL SERVICES AT THE TIME TREATMENT IS RENDERED. We accept Visa, MasterCard, Discover, American Express, Care Credit, Cash or Check.

INSURANCE FILING- THE PATIENT IS ULTIMATELY RESPONSIBLE FOR PAYMENT IN FULL OF THEIR ACCOUNT, NOT THE INSURANCE COMPANY. We do, however, file dental insurance claims as a courtesy to our patients. We can ONLY make ESTIMATES regarding your insurance benefits based on the information provided by you and your insurance company. In the event your insurance company does not pay as much as expected, the remaining balance is due and payable immediately by you, the patient.

Also, if we have not received payment from your insurance company within 60 days, YOU are responsible for paying the entire amount, and then to seek reimbursement from your insurance company. In the event that your account is ever over-paid, you will be given a credit on your account to be used for future dental care, or a refund will be issued.

ASSIGNMENT OF INSURANCE BENEFITS- I/We hereby assign directly to FALCON DENTAL CARE dental benefits otherwise payable to me/us. I/We hereby authorize the release of any information relating to any claims. I/We understand that I/We are financially responsible for charges not paid by this assignment.

RETURNED CHECKS OR NSF ACH DEBITS- In the event your check is returned unpaid due to insufficient funds, you authorize your check to be electronically redeposited for the face amount of the check. Recovery fees, as applicable by state law, will be assessed on all returned checks and **may** be collected from your checking account, and/or billed directly to you. By presenting your check for payment for your transaction, you are acknowledging your acceptance of our Check Acceptance Policy. In the event your account does not have the authorized funds to be debited you will be charged a minimum of \$25 per NSF transaction. This fee applies to both checks and ACH Debits.

DELINQUENT ACCOUNTS- All delinquent accounts (30 days or older) are subject to reasonable service charges and/or legal interest rates.

COLLECTION PROCEEDINGS- In the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any collection costs and/or attorney fees, in addition to the balance owed. Any account turned over to a collection agency forfeits any past special fees and/or discounts. Such special fees and/or discounts will be reversed and you will be responsible for payment of regular fees for procedures at the time of service.

CANCELLATION/TARDINESS- WE REQUIRE A 24 HR. NOTICE FOR ALL CANCELLED APPOINTMENTS. Individuals who fail to show for an appointment are subject to a cancellation fee of \$50.00 per hour based on the length of the missed appointment time. We do understand that situations arise, (such as a sick child) and we are very sympathetic of those situations. A TARDINESS of more than 15 minutes for an appointment WILL be rescheduled.

DUPLICATION FEE- There will be a \$50 duplication fee per family to copy all x-rays.

I HAVE COMPLETELY READ AND UNDERSTAND THE CONTENTS OF THIS AGREEMENT. I AGREE TO COMPLY WITH ALL OFFICE POLICIES.

Responsible Party Signature _____ Date: _____

Office Staff Signature _____ Date: _____



Our office is an amalgam free office, which means *we do not do any silver fillings*. All of our fillings are done with resin material that is matched to the color of your teeth.

Most insurance companies will pay as though an amalgam filling was done because they are less expensive. For example, if the resin filling costs \$100, the insurance company may pay for that same filling done as an amalgam (silver) filling which may be \$80 they would then pay their percentage based on that lower fee.

If your plan says they pay 80% of restorative procedures (such as fillings, etc.), they really end up paying 80% of the cost of a silver filling. It is your responsibility as the patient to pay the difference.

We do our best to estimate what your costs will be. We are always glad to answer any questions you may have.

Thank you for being part of our dental office. We enjoy being able to help you with your dental needs.

Your signature states that you understand the above.

Patient/Guardian Signature

Date



Notice of Privacy Practice Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers (ie insurance, financing companies)

Conduct normal health care operations such as quality assessments and physician certifications.

I acknowledge that I have received your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name _____

Signature _____

Relationship to Patient _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patients' signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____

Reason: _____

