PATIENT INFORMATION

Patient Name: _____ Preferred Name _____ Male / Female
Last First MI

Birth Date: _____ Social Security #: _____ Single / Married / Divorced / Widowed / Child

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

Address: _____
Street Apt # City State Zip Code

Email address: _____

Whom may we thank for referring you to our practice?_____

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

HEALTH INFORMATION

PLEASE LIST <u>ANY</u> MEDICATIONS YOU ARE CURRENTLY TAKING:_____

_____

Do you have, or have you had, any of the following? Please check YES or NO:

Y	N		Y	N		Y	N		Y	N	
☐	☐	PREMED- Amoxicillin	☐	☐	Arthritis	☐	☐	Head Injuries	☐	☐	Psychiatric Care
☐	☐	PREMED- Clindamycin	☐	☐	Asthma	☐	☐	Heart Disease	☐	☐	Radiation Treatment
☐	☐	PREMED- Other	☐	☐	Blood Disease	☐	☐	Heart Murmur	☐	☐	Respiratory Problems
☐	☐	Allergies- Seasonal	☐	☐	Blood Pressure- H IGH	☐	☐	Heart Surgery	☐	☐	Rheumatic Fever
☐	☐	Allergy - Aspirin	☐	☐	Blood Pressure-LOW	☐	☐	Hepatitis A/B/C	☐	☐	Scarlet Fever
☐	☐	Allergy- Erythromycin	☐	☐	Blood Transfusion	☐	☐	Herpetic/Cold Sores	☐	☐	Shortness of Breath
☐	☐	Allergy- Food	☐	☐	Bruises Easily	☐	☐	HIV/Aids	☐	☐	Sinus Problems
☐	☐	Allergy- Latex	☐	☐	Cancer	☐	☐	Hypoglycemia	☐	☐	Stomach Problems
☐	☐	Allergy- Other	☐	☐	Chemotherapy	☐	☐	Kidney Disease	☐	☐	Stroke
☐	☐	_____	☐	☐	Diabetes	☐	☐	Liver Disease	☐	☐	Swelling of Feet / Ankles / Hands
☐	☐	Allergy- Penicillin	☐	☐	Dizziness	☐	☐	Lung Disease	☐	☐	Thyroid Disease
☐	☐	Allergy- Sulfa	☐	☐	Emphysema	☐	☐	Mental Disorders	☐	☐	Tuberculosis
☐	☐	Anemia	☐	☐	Epilepsy	☐	☐	Mitral Valve Prolapse	☐	☐	Tumors
☐	☐	Alzheimer's Disease	☐	☐	Excessive Bleeding	☐	☐	Neurological Disorder	☐	☐	Ulcers
☐	☐	Artificial Heart Valve	☐	☐	Fainting	☐	☐	Pacemaker	☐	☐	STD
☐	☐	Artificial Joints	☐	☐	Glaucoma	☐	☐	Pregnancy Due Date:_____	☐	☐	Other _____

- Do you CURRENTLY take an antibiotic premed prior to dental treatment? ☐ Yes ☐ No If yes, please explain: _____
- Have you 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** : _____
- Are you now under the care of a physician? ☐ Yes ☐ No If yes, please explain : _____

In case of emergency, whom shall we call: Name _____ **Relationship** _____

Phone Numbers: _____

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, or if my medicines change, I will inform the doctors at the next appointment without fail.

X_____ Date: _____
Signature of patient, parent or guardian

RESPONSIBLE PARTY & INSURANCE INFORMATION

(If other than patient)

Name: _____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Social Security #_____-_____-_____ Birth Date: _____

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

Address: _____
Street Apartment # City State Zip Code

PRIMARY INSURANCE INFORMATION

Employer Name & Address: _____

Insurance Plan Name: _____ Group #: _____ Phone Number:_____

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

Consent for Services

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing, unless previous financial arrangements have been made.

All emergency dental services, or any dental service performed without prior financial arrangements, must be paid at the time the services are performed. If I carry insurance, I understand that this office will help prepare my **PRIMARY** insurance forms to assist in making collections from that insurance carrier and will credit such collections to my account.

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. Since it is not possible to coordinate insurance payments from any **SECONDARY INSURANCE CARRIER,** we are unable to accept payment from your secondary insurance. We will be happy to assist you when you file for your reimbursement from that carrier.

A service charge of 1 ½% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) or $15.00 minimum per month will be charged on the unpaid principal balance (including insurance payments due) on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

I agree to the above stated conditions and I hereby authorize treatment and direct payment of the dental benefits otherwise payable to me, directly to Dr. Gregory D. Hellmann.

If I have any questions concerning my treatment or any options, I will request additional information from Dr. Hellmann or his staff.

X_____ **Date:** _____
Signature of Patient / Responsible Party / Parent or Guardian