

DAVIS FAMILY DENTAL

Please print / Favor de usar imprenta

First Name / Primer Nombre: _____ Last Name / Apellido: _____ Middle Initial: _____

Responsible Party / Persona Responsable

First Name / Primer Nombre: _____ Last Name / Apellido: _____ Middle Initial: _____

Address / Dirección: _____

City / Ciudad: _____ State / Estado: _____ Zip / Código: _____

Home Phone / Telefono de Casa: _____ Work Phone / Telefono de Trabajo: _____ Cellular / Celular: _____

Birth Date / Fecha de Nacimiento: _____ Social Security / Seguro Social: _____

Patient Information / Información del Paciente

First Name / Primer Nombre: _____ Last Name / Apellido: _____ Middle Initial: _____

Address / Dirección: _____

City / Ciudad: _____ State / Estado: _____ Zip / Código: _____

Home Phone / Telefono de Casa: _____ Work Phone / Telefono de Trabajo: _____ Cellular / Celular: _____

Birth Date / Fecha de Nacimiento: _____ Age / Edad: _____ Social Security / Seguro Social: _____

Sex / Sexo: Male Female Marital Status / Estado Civil: Single Married Divorced Occupation / Ocupación: _____

Medicaid ID: _____ Pharmacy / Farmacia: _____

Primary Insurance / Seguranza Principal

Name of Insured / Dueño de la Seguranza: _____ Relationship to Patient / Relación al Paciente: Self Spouse Child Other

Insured SS#: _____ Insured Date of Birth: _____

Employer / Empleador: _____ Address / Dirección: _____

Insurance Company / Nombre del Seguro: _____ Address / Dirección: _____

Secondary Insurance / Segunda Seguranza

Name of Insured / Dueño de la Seguranza: _____ Relationship to Patient / Relación al Paciente: Self Spouse Child Other

Insured SS#: _____ Insured Date of Birth: _____

Employer / Empleador: _____ Address / Dirección: _____

Insurance Company / Nombre del Seguro: _____ Address / Dirección: _____

How did you hear about us? / Como se enteró de nuestra clinica?

- Drive-by / Cartel de la Clinica Insurance / Seguro Friend or Family / Amigos o Familia Church Bulletin / Propaganda en la Iglesia
 Ward Parkway Mall Advertisement / Propaganda en el "mall" Hispano Plan / Plan hispanico Other: _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, the mouth is a part of your entire body. Health problem you may have, or medications that you may be taking, could have an important correlation with the dentistry you will receive. Thank you for answering the following questions.

- Are you currently under a physician's care? / *Ve a un medico frecuentemente?* Yes No If yes, please explain: _____
- Have you been hospitalized or had major operation? / *Estuvo internado?* Yes No If yes, please explain: _____
- Have you had a serious head or neck injury? / *Tuvo herida del cuello o de cabeza?* Yes No If yes, please explain: _____
- Are you taking any medication, pills or drugs? / *Toma medicamentos, pastillas o drogas?* Yes No If yes, please explain: _____
- Do you take Phen-Fen or Redux? / *Toma Phen-Fen o Redux?* Yes No If yes, please explain: _____
- Are you on a special diet? / *Esta en una dieta especial?* Yes No If yes, please explain: _____
- Do you use tobacco? / *Usa tabacco?* Yes No If yes, please explain: _____
- Do you use controlled substance? / *Usa sustancias controladas?* Yes No If yes, please explain: _____
- Women / *Mujeres:* Pregnant or Trying / *Esta Embarazada o Tratando?*
 Taking oral contraceptives / *Esta tomando contraceptivos?*

Are you allergic to any of the following? / *Tiene alergia al siguiente?*

- Asprin / *Aspirina* Penicillin / *Penicilina* Codeine / *Codeina* Acrylic / *Acrilico* Metal Latex Other:

Do you have, or have had, any of the following? / *Tiene o tuvo algunos de los siguientes?*

- | | | | |
|---|--|---|---|
| <input type="radio"/> AIDS or HIV | <input type="radio"/> Cortisone Medicine | <input type="radio"/> Hemophilia | <input type="radio"/> Renal Dialysis |
| <input type="radio"/> Alzheimer's Disease | <input type="radio"/> Diabetes | <input type="radio"/> Hepatitis A | <input type="radio"/> Rheumatic Fever |
| <input type="radio"/> Anaphylaxis | <input type="radio"/> Drug Addiction | <input type="radio"/> Hepatitis B or C | <input type="radio"/> Rheumatism |
| <input type="radio"/> Anemia | <input type="radio"/> Easily Winded | <input type="radio"/> Herpes | <input type="radio"/> Scarlet Fever |
| <input type="radio"/> Angina | <input type="radio"/> Emphysema | <input type="radio"/> High Blood Pressure | <input type="radio"/> Shingles |
| <input type="radio"/> Arthritis or Gout | <input type="radio"/> Epilepsy or Seizures | <input type="radio"/> Hives or Rash | <input type="radio"/> Sickle Cell Disease |
| <input type="radio"/> Artificial Heart Valve | <input type="radio"/> Excessive Bleeding | <input type="radio"/> Hypoglycemia | <input type="radio"/> Sinus Trouble |
| <input type="radio"/> Artificial Joint | <input type="radio"/> Excessive Thirst | <input type="radio"/> Irregular Heartbeat | <input type="radio"/> Spina Bifida |
| <input type="radio"/> Asthma | <input type="radio"/> Fainting Spells or Dizziness | <input type="radio"/> Kidney Problems | <input type="radio"/> Stomach or Intestinal Disease |
| <input type="radio"/> Blood Disease | <input type="radio"/> Frequent Cough | <input type="radio"/> Leukemia | <input type="radio"/> Stroke |
| <input type="radio"/> Blood Transfusion | <input type="radio"/> Frequent Diarrhea | <input type="radio"/> Liver Disease | <input type="radio"/> Swelling of Limbs |
| <input type="radio"/> Breathing Problem | <input type="radio"/> Frequent Headaches | <input type="radio"/> Low Blood Pressure | <input type="radio"/> Thyroid Disease |
| <input type="radio"/> Bruise Easily | <input type="radio"/> Genital Herpes | <input type="radio"/> Lung Disease | <input type="radio"/> Tonsillitis |
| <input type="radio"/> Cancer | <input type="radio"/> Glaucoma | <input type="radio"/> Mitral Valve Prolapse | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Chemotherapy | <input type="radio"/> Hay Fever | <input type="radio"/> Pain in Jaw Joints | <input type="radio"/> Tumors or Growths |
| <input type="radio"/> Chest Pains | <input type="radio"/> Heart Attack | <input type="radio"/> Parathyroid Disease | <input type="radio"/> Ulcers |
| <input type="radio"/> Cold Sores | <input type="radio"/> Heart Murmur | <input type="radio"/> Psychiatric Care | <input type="radio"/> Venereal Disease |
| <input type="radio"/> Congenital Heart Disorder | <input type="radio"/> Heart Pace Maker | <input type="radio"/> Radiation Treatments | <input type="radio"/> Yellow Jaundice |
| <input type="radio"/> Convulsions | <input type="radio"/> Heart Disease | <input type="radio"/> Recent Weight Loss | |

Are you unhappy with your smile? Please explain why. / *Esta descontento con su sonrisa? Explique.* _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Legal Guardian / *Firma del Paciente o Padres*

Today's Date / *Fecha*

FINANCIAL AGREEMENT

A Message To Our Patients About Our Payment Policy

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our policy.

Payment for services is due at the time services are rendered unless payment and arrangements have been approved in advance. We accept most major credit cards.

We will be happy to help you process your insurance claim form; however, any such requests must be accompanied by a completed insurance form and copy of your insurance card. We will accept assignment of insurance benefits, but we request your co-payment at the time of service. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. As a service to you, we will predetermine your dental benefits for you on large treatment plans. Generally, we receive this information within 4 to 5 days after we submit it. If, for whatever reason, your predetermination is not received in our office prior to your appointment, we require that you pay 50% of the services rendered at the time of the appointment. Any adjustments will be made when payment is received from your insurance carrier. Please keep in mind, that a predetermination is only an estimate, not a guarantee of payment.

If you have more than one insurance carrier, please advise the dental personnel. We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility, due and payable on the day of service. It is your responsibility to understand what your insurance does and does not cover prior to your visits.

We realize that temporary financial hardships may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in management of your account. Returned checks will be subject to a \$30 service charge. When an account is more than 60 days past due, the undersigned agrees that interest on the account balance will be assessed and paid at the rate of 1.5% a month on the unpaid balance. Charges may be made for broken and/or cancelled appointments. If an account becomes delinquent and communication was not attempted on your part, your account will be at risk and possibly sent to a collection agency.

The following guidelines have been established for payment of financial obligations for services rendered in our office. Please read carefully and select the payment option most suitable for your situation. Your signature is required to assure that there is no misunderstanding regarding your financial obligation and all the above stated.

Cash or Check (Payment at time of service)

Credit Card

Insurance – Patient co-payment is due at the time of service. Since all insurance is an estimate, any portion not paid by your insurance is your responsibility. If insurance does not pay within 90 days, payment is expected by the patient or contact must be made with our dental personnel. If checking this option, please select one of the first two options for your portion of co-payment or deductibles.

I am eligible for your 10% Senior Citizen Discount (55+)

I have read the above agreement and selected a payment option. I understand my financial obligations with this office.

Signature: _____

Date: _____