Patient Information

Patient Name: ____ Date:_______________
Last First MI

☐ Male ☐ Female * ☐ Married ☐ Single ☐ Child

Social Security #: _______________ Birth Date:_______________ E-Mail____________________

Phone (Home): ________________(Work): ________________ (Cell):________________

Address: ____
Street Apartment #

____
City State Zip Code

Employer: ____

Emergency contact and phone number: ______________________________

School(for full time college students): ______________________________

Responsible Party Information

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ______________

Social Security #: ____________________ Birth Date:____________________

Phone (Home): ________________(Work): ________________ (Cell):________________

Address: ____
Street Apartment #

____
City State Zip

Employer: ____

Insurance Information

Primary

Name of Subscriber: ______________________________ Is subscriber a patient? ☐ Yes ☐ No
Last First MI

Subscriber's Birth Date: ____________________ Subscriber's SS #: ____________________

Subscriber's Address: ____
Street City State Zip Code

Subscriber's Employer Name: ______________________________

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other______________

Insurance Plan Name and Address: ______________________________

____

ID #: ______________________Group #:______________________

Secondary

Name of Subscriber: ______________________________ Is subscriber a patient? ☐ Yes ☐ No
Last First MI

Subscriber's Birth Date: ____________________ Subscriber's SS #: ____________________

Subscriber's Address: ____
Street City State Zip Code

Subscriber's Employer Name: ______________________________

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other______________

Insurance Plan Name and Address: ______________________________

____

ID #: ______________________Group #:______________________

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient-Name ______________

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other______________

Name: ________________________________ Health Information

Date of Last Dental Visit: __________________ Reason for this visit:___________________________________

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

☐ AIDS/HIV
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Chemical Dependency
☐ Congenital Heart Defects
☐ Diabetes
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Heart Attack/Trouble
☐ Heart Murmur
☐ Hearing Impaired
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Oral Herpetic Lesions
☐ Psychiatric Care
☐ Pacemaker
☐ Pregnancy
Due date:_________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Stomach Problems
☐ Tumors
☐ Ulcers
☐ Venereal Disease

Pre-Medicate ☐ Yes ☐ No Reason to Pre-medicate ___________________

Allergies:

☐ Penicillin ☐ Other Antibiotics ☐ Codeine/Aspirin ☐ Local Anesthetic ☐ Latex ☐ Sulfa Drugs ☐ Other Allergies_______

Medications:

_____________________________ _____________________________ __________________________

_____________________________ _____________________________ __________________________

Tobacco Use in any form? If yes how much?____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:____
- Are you happy with the appearance of your smile? ☐ Yes ☐ No
  If no, please explain:____
- Are you concerned with grinding your teeth? ☐ Yes ☐ No
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:____
- Is there anything else that would be valuable for your dentist to know?
  ____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:____
- Name of Physician: ____ Phone:______________________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:____

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, I will inform the doctors at the next appointment without fail.

____ Date:_____________________
Signature of patient, parent or guardian

Consent for Services & Guaranty of Payment

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I also understand and agree that if I am in default of this agreement, I will pay all reasonable legal fees, court costs, and other costs necessary to collect the debt, including fees charged by a collection agency.

I understand that the fee estimate listed for this dental care can only be extended for a period of four months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore 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 if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

____ Date: ________________ Relationship to Patient: __________
Signature of patient, (parent or guardian if minor)

____ Date: ________________ Relationship to Patient: __________
Signature of guarantor of payment/responsible party

NOTICE OF PRIVACY ACKNOWLEDGEMENT

Dr. James S. Perry
403 East First Avenue
Shakopee, MN 55379

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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.
Conduct normal healthcare 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 healthcare operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

Patient Name (print): ____

Signature: ___________________________________ Date: _____________

Relationship to Patient: ____

Other persons that you may discuss my account / treatment with:

____