



EAU CLAIRE • CADOTT • CHIPPEWA FALLS • STANLEY • THORP

PATIENT INFORMATION

Name Address City Zip Code Home Phone Cell Phone Birth date Sex M F Employer Bus Ph# Social Security Marital Status Name of Spouse Email Address If student, name of school/college Emergency Contact Phone Which way do you prefer to have your appointments confirmed? (You may choose more than one) Home Work Cell Phone Text Email Who may we thank for referring you to our practice? Insurance Yellow Pages Internet Other (below) Name of person, office, or other source referring you to our practice:

RESPONSIBLE PARTY INFORMATION

Name Address City Zip Code Home Phone Cell Phone Birth date Sex M F Employer Bus Ph# Social Security Drivers License # Financial Institution Relationship to Patient For your convenience, we offer the following methods of payment. Please check the option you prefer for payment in full (or patient portion/co-pay if there is insurance) at each appointment: Cash Check Credit Card I wish to discuss payment arrangements

DENTAL INFORMATION

Sensitivity to heat/cold Yes No Sensitivity to sweets Yes No Teeth straightened Yes No When Unpleasant taste Yes No Frequent Headaches Yes No Popping clicking noises in jaw Yes No Clenching or grinding Yes No Frequent daytime fatigue Yes No Date of last Dental exam Why are you seeking care at this time? Do you drink soda? Yes No Cans per day: Do you smoke? Yes No Chew tobacco? Yes No

PRIMARY DENTAL INSURANCE INFORMATION

Name of Insurance Carrier _____ Group # _____
Ins Company Phone Number _____ Subscriber Employer _____
Name of Subscriber _____ D.O.B. _____ Subscriber SS# _____

SECONDARY DENTAL INSURANCE INFORMATION (if applicable)

Name of Insurance Carrier _____ Group # _____
Ins Company Phone Number _____ Subscriber Employer _____
Name of Subscriber _____ D.O.B. _____ Subscriber SS# _____

FINANCIAL AGREEMENT AND AUTHORIZATION

Financial Policy of the Dental Health Center

Financial consideration should not be an obstacle to obtaining this important, life-enhancing care. We are always available to answer your questions and/or assist you in any way we can.

For Our Patients With Insurance: We are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage, however you are ultimately responsible for knowing what your benefits coverage consists of. To better assist you, we are familiar with many insurance plans and will calculate *as best we can* what your co-payment and deductible will be and this will be discussed with you prior to your treatment. However, we are not responsible for how much or when your insurance company pays on your claim. We ask to have your portion paid within 30 days of your treatment. This minimizes the need to send statements, thereby allowing us to offer affordable dental treatment.

For Our Patients Without Insurance: We expect payment in full on the day services are rendered and have three payment options available for you:

- ✓ Payment in full with a 15% discount.
- ✓ We also accept all major credit cards with a 12% discount.
- ✓ Interest free financing through Care Credit and Citibank

*Seniors (62 and older) receive a 10% discount **plus** another 5% paid day of service with cash or personal check (12% discount if paid by credit card on day of service).

*Discounts do not apply to certain insurance companies or special packages

*Discounts may not be combined

In order to best accommodate our patients and keep our schedule full, we require **2 business days** notice should you need to change an appointment. Appointments changed with less notice than this will be assessed a \$25 fee. Missed appointments will be charged \$30. Also note, there will be a \$35 service charge applied for all returned checks.

I certify that I have read and understand the above information to the best of my knowledge. I authorize my insurance company to pay directly The Dental Health Center any insurance benefits otherwise payable to me. I agree to be responsible for payment of all services rendered on my behalf or my dependents, regardless of insurance coverage.

YOU WILL SIGN THIS EXACT FORM ON THE SIGNATURE PAD ONCE IT IS ENTERED INTO THE COMPUTER. PLEASE ASK IF YOU WOULD LIKE A COPY FOR YOUR RECORDS.

MEDICAL INFORMATION

(Women) Are you taking birth control pills? Y N Are you pregnant? Y N Are you breastfeeding? Y N

Are you currently under the care of a physician? Y N If yes, for what reason? _____

Please list all allergies you have _____

Have you ever been advised to pre-medicate with antibiotics before having dental treatment? Yes No

Have you ever taken Fosamax, Boniva, Actonel, or any cancer medications containing biophosphonates? Yes No

Please list all medications you are presently taking, including aspirin/baby aspirin and Cancer medications (Zometa/Aredia). _____

DO YOU HAVE OR HAVE YOU EVER HAD:					
Arthritis	Yes	No	Rheumatic fever	Yes	No
Asthma or hay fever	Yes	No	Chemical Dependency	Yes	No
Congenital heart defects	Yes	No	Fainting or seizures	Yes	No
High blood pressure	Yes	No	Excessive urination/thirst	Yes	No
Low blood pressure	Yes	No	Malignant Hypothermia	Yes	No
Diabetes	Yes	No	HIV Positive	Yes	No
Epilepsy	Yes	No	Excessive/prolonged bleeding	Yes	No
Cancer	Yes	No	Taking blood thinner	Yes	No
Psychiatric care	Yes	No	Sinus trouble	Yes	No
Radiation therapy	Yes	No	Thyroid problem	Yes	No
Stroke	Yes	No	Pace Maker	Yes	No
Prosthetic implant	Yes	No	Tumors	Yes	No
Artificial joints	Yes	No	Kidney disorders	Yes	No
Tuberculosis or lung disease	Yes	No	Heart disease	Yes	No
Hepatitis	Yes	No	Heart attack	Yes	No
Herpes simplex (cold sores)	Yes	No	Heart Murmur	Yes	No
Latex Allergy	Yes	No	Circulatory problems	Yes	No

Is there anything else I should know about your medical history? _____

Primary Care Physician and Clinic _____

You do not need to sign this form as we will enter this into the computer and have you sign an electronic signature pad.

When I sign the form electronically, I certify that I have read and understand the above information to the best of my knowledge.