Chart #:_____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date:_____

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

Email: _____Driver's Lic# _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: _____
Street Apartment #

_____
City State Zip Code

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
☐ Allergies _____ _____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ _____
☐ _____

Please List any medications you are taking or have taken in the last 3 months:
_____

- Have you ever 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:_____
- 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

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

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

Name of person or office referring you to our practice:_____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Acknowledgement of Privacy Practice Acts

I acknowledge that I received a copy of Pure Dental's Notice of Privacy Practices.

Patient Name: _____

Signature: _____ **Date**_____

Pure Dental's Financial and Failed Appointment Policy

Our fees are based on the quality of the products and materials we use and our experience in performing your scheduled treatment. We offer early mornings (7 AM) and evening (7 PM) appointments for your convenience.

Our goal is not to let expense prevent you from benefiting from the quality of care you desire and need. We also realize that every patient's financial situation is different. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

- Payment is due in full at the time of service.
- For patients who have insurance, the entire estimated patient portion is due at the time of service.
- We ask that you read and be aware of your insurance benefits, exclusions and frequency limitations. Every plan is different and changes do occur frequently.
- We will perform an initial insurance verification and do our best to provide you an estimate of your co-pay prior to your appointment. If you are covered by 2 insurance companies, you need to be aware of a duplication clause and verify whether or not your secondary insurance has standard coordination of benefits or not. This may limit your secondary insurance payment.
- As a courtesy, we will gladly process your insurance claims and estimate the amount not covered by your insurance. All incurred charges are ultimately the responsibility of the patient regardless of insurance coverage and are due within 45 days of service.
- Any balance over 90 days old will be subject to a 2.0% monthly finance charge.
  Returned checks for insufficient funds or closed accounts are subject to a $50.00 fee. If a check is returned, cash, Visa, American Express, or MasterCard will be the only accepted form of payment.
- If a collection agency becomes involved in the settlement of your account, all collection costs and legal fees for both parties are the responsibility of the account holder.
- An appointment that has been cancelled or rescheduled within 48 business hours of appointment time or failure to arrive at scheduled appointment is defined as a failed appointment. ***Any failed appointment (except emergencies) is subject to a $50 charge per hour scheduled.***
- ***Appointments scheduled 1 hour or longer may require a 20% deposit, which in part will be used as your cancellation fee in the event of a failed appointment.***

Although we are unable to arrange payment plans through our office, Pure Dental offers third party financing through Care Credit. Care Credit offers low, and in some cases, 0% interest payment plans. You can apply online or in our office and we usually receive approval in less than 15 minutes.

We welcome you to Pure Dental and look forward to helping you achieve the healthy, beautiful smile of your dreams! If there is anything we can do to make your visit more pleasant, please do not hesitate to ask myself or one of our team members.

I have read and understand Pure Dental's financial and failed appointment policies:

Signature of patient/ guardian _____ Date _____