Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

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

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
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ _____
- ☐ **Pregnancy**
  Due date:_____

- Please list any and all medication(s) and dosages you are currently taking:_____
_____
_____

- 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

Emergency Contact

Name: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____
Last First MI

Is insured a patient? ☐ Yes ☐ No

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: _____

_____

Consent for Services

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 on the part 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 understand that the fee estimate listed for this dental care can only be extended for a period of six 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

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

FINANCIAL AGREEMENT

Thank you for choosing Torrens Dental Care as your dental health care provider. We are committed to providing the highest quality of dental care and continued maintenance of your oral health. Please understand that paying for your dental work is considered to be an integral part of your ongoing treatment. The following is a statement of our Financial Agreement, which we require you to read and sign prior to any treatment. Full payment is due at the time of service. For your convenience we accept cash, check, Visa, Master Card, American Express and Discover. We also offer an extended payment plan through Independent credit companies with credit approval.

REGARDING DENTAL INSURANCE

All co-pay and deductibles are due on the date of service. The balance is your responsibility whether your insurance company pays or not. Please remember, we submit insurance as a courtesy to you. You are responsible for all charges incurred in this office. Your ultimate reimbursement rests with your insurance company. At Torrens Dental Care we strive for excellent dentistry. As such, we are a mercury-free office. Insurance companies often offer an alternative benefit in paying for posterior composites. You are responsible for the difference in the fee of the mercury containing restoration and the mercury free restoration. Please contact your individual insurance company for specifics on their compensation policy.

MINOR PATIENTS, STUDENTS AND DEPENDANTS

The adult accompanying a minor and/or the parent (or guardians of the minor or students) are responsible for full payment. For unaccompanied minors or students, non emergency treatment will not be provided unless the charges have been pre-authorized to an approved credit plan, credit card, or payment by cash or check at the time services have been rendered as well as the prior consent of the service to be provided to the minor.

MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments ($30.00) if an emergency situation arises that prevents you from keeping your appointment, please let us know as soon as possible so we can reschedule your appointment. Please help us serve you better by keeping your scheduled appointments.

Thank you for understanding our Financial Agreement. Please let us know if you have any questions or concerns.

I have read the Financial Agreement, and I understand and agree to its terms and conditions.

_____ _____

Signature of responsible party Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's notice of Privacy Practices.

_____

Please Print Patient Name

_____

Please Print Parent/Guardian Name

_____

Patient / Parent or Guardian Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ Individual refused to sign

□ Communications barriers prohibited obtaining the acknowledgement

□ An emergency situationprevented us from obtaining acknowledgement

□ Other (Please Specify)

_____

_____

_____