

Patient Information

How did you hear about us? _____

Patient Name: _____ Date: _____

Email Address _____

Social Security #: _____ Birth Date: _____ Married _____ Single _____

Home Phone _____ Cell Phone _____ Work Phone _____

Address _____

Employer Name: _____ Occupation _____

HEALTH INFORMATION

Date of Last Dental Visit _____ Reason for this visit: _____

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

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Head Injuries | Due date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Aspirin Therapy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | |

- 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: _____

- Do you wear a complete denture or a partial denture? Yes ___ No ___

- Are you now under the care of a physician? Yes No

If yes, please explain: _____

- List all medications including Vitamins _____

• Name of Physician: _____ Phone: _____

- Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

All preceding answers and information are true and correct. I will inform the doctor of any changes immediately.

Signature of patient, parent or guardian _____ Date: _____

FINANCIAL ARRANGEMENT AND TREATMENT POLICY

We feel that everyone benefits when there is a definite and clear understanding of our treatment and financial policies prior to treatment. They are intended to allow us to be fair to our entire family of patients and help control administrative costs.

APPOINTMENTS

We have exclusively reserved the doctor, staff and facility for your personal dental care. We would appreciate your consideration in giving us a 48 hour notice so that we may effectively re-utilize the time with the doctor or hygienist.

FAILED APPOINTMENT

MORE THAN 2 MISSED APPOINTMENTS WILL NO LONGER BE RESEVERD

FEES

The fees for your dental treatment are based on the treatment rendered and the time needed to complete the treatment. Our office believes the fees are a fair representation of the standard of care we provide and in step with industry standard. Treatment is based on necessity not on insurance benefits. Treatment plans may change during the course of treatment based on treatment needs. All fees are due and payable before treatment is commenced. Once treatment has commenced, there are no refunds. Any financial courtesy afforded you will be removed if treatment is not completed. A deposit of \$250.00 will be required to hold an appointment time over 1 hour in length. This is non – refundable.

INSURANCE

I hereby guarantee payment of all charges incurred for services rendered at PROCARE DENTISTRY by Dr. .Melanie Allen. P.A. I understand the cost of medical care is dependent upon the nature and complexity of my dental needs, which can only be established by the Dentist. I understand that any VERBAL information given to me by PROCARE DENTAL staff regarding fees and services is for informational purposes only and is no way a contract between, PROCARE DENTISTRY and me. NO VERBAL contracts have been made or will be honored. As a courtesy, we will bill your insurance company for treatment rendered, provided we have current and accurate benefit coverage information. Your insurance may contain an alternate benefits clause or there may be procedures that are not covered which may affect the amounts paid by your insurance. It is your responsibility to be aware of these clauses for your particular insurance and the effect on the amounts due. Please understand your dental insurance is a contract between you and your insurance company and therefore you are responsible for any unpaid balance on your account. We will expect you to pay your deductible and any out-of-pocket portions before services are rendered. If your insurance carrier does not make a payment within 45 days you will be notified. If payment is not received within 60 days we will bill you for any outstanding balance. It is important to understand your actual insurance benefits may differ from the benefits estimated in your Treatment Plan Estimate. Your Treatment Plan Estimate is based on information provided by your insurance company and by you. It is an estimate only is not a guarantee of payment from the insurance company.

COLLECTIONS

In the event your account is not paid in full within 90 days, the cost for all attorney fees, 40% collection fees of the original amount due and /or cost of litigations shall be incurred by the person responsible for the account. * *In addition to the foregoing, the parties agree that the liquidated sum of \$500 will be added to any court judgment obtained by Dr. Melanie Allen., P.A., upon rendering of said judgment, for reasonable cost in connection with recording and certifying the judgment and any execution. The patient firmly agrees that, to the extent that any court fails or declines to enforce this immediately preceding provision, Dr. Melanie Allen., P.A., shall be allowed to seek and receive an award of cost of execution as allowed by the law.**The provisions of this agreement are severable. This agreement is intended to be constructed in accordance with its fair meaning, and without regard to the presumption that agreements are to be constructed against draft or. This agreement is to be constructed in accordance with Florida law without regard to Florida's choice of laws provisions. This agreement shall terminate when the patient /responsible party files for bankruptcy.

RETURNED CHECKS

There is a 45.00 charge for any returned checks.

Our office would like to thank you for your time, cooperation and trust in us to deliver comfortable, safe and quality dental care to you, your family and friends. We also appreciate your understanding in the necessity of the aforementioned guidelines and procedures. I have read, understand and have received a copy of the following Disclosure Statement. I agree to pay the aforementioned fees.

Patient/ Responsible party signature

Date

