CrabappleDental

## Patient Information

Patient Name: _____DOB:_____
Address: _____ Apt#_____
City: _____ State: _____ Zip Code: _____
Home# _____ Work_____ Cell _____
Email _____ Social Security #_____Marital Status ____
Employer_____ Emergency Contact_____ Tel# _____

## Responsible Party Information

Name:_____ Relationship to Patient_____
Social Security#_____ Birth Date: _____ Home#_____
Work# _____ Cell: _____ Best time to call: _____
Mailing Address: _____

## Health Information

Date of Last Dental visit: _____Reason for this visit:_____
Have you ever had any of the following? Please check all that apply:

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

- 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

- 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:_____
- Please list any medications you are taking:
  _____
  _____
  _____

## Referral Information

Whom may we thank for referring you to our practice? __Newspaper __Work __ School __ Friend __ Relative __ Dental Office __ Yellow Pages __Other_____

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

## Insurance Information

Name of the policy holder:_____
Insured's birth date: _____ SS#_____ group#_____
Name of Employer_____ Name of Insurance Co_____
Insurance Co. tel#_____ Patient's Relationship to insured:_____

WE FILE PRIMARY INSURANCE ONLY AS A COURTESY. THE PATIENT MUST FILE SECONDARY INSURANCE. WE WILL PROVIDE YOU WITH ALL THE NECESSARY PAPERWORK ON OUR PART TO FILE FOR YOUR BENEFITS.

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS AND INFORMATION PROVIDED ARE TRUE AND CORRECT. IF I EVER HAVE A CHANGE IN MY HEALTH, I WILL INFORM THE DOCTORS AT THE NEXT APPOINTMENT WITHOUT FAIL.

_____ Date: _____
Signature of patient, parent, or guardian

CrabappleDental

## 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.

I WILL BE PAYING FOR TREATMENT BY:
___ CASH
___ CHECK (RETURNED CHECK FEE 45.00)
___ CREDIT CARD
___ DENTAL FEE PLAN (FINANCING)

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid in cash at the time services are performed. Any appointment that has not been cancelled within 48 hrs of the appointment, and a no show, or cancellation at the last minute will result in a $75.00 broken appointment charge. Patients that are using dental insurance should understand that ALL dental services performed are charged directly to the patient and the patient or guardian of a patient is personally responsible for payment of ALL dental services. This office will help prepare insurance claims or assist in collecting from the insurance company and will credit any such collections to the pt's account. However, this office does not render services on the assumption that our charges will be paid by an insurance company. If your insurance company does not pay its portion of the bill within 45 days, the account balance will be transferred to the patient, and immediate payment will be expected.

I agree to pay for services at the time said services are rendered. 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 were instituted hereunder. Delinquent accounts will be charged a finance fee equal to 18% per annum and other penalties or collection fees may be also added.

I grant my permission to Crabapple Dental, to telephone me at home or at my work, or contact me on the weekend to discuss matters related to this form or my account.

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

Signature of patient, parent, or guardian  Date  Relationship to patient