PERSONAL DATA

Last name _____First name _____ Middle_____

Address_____

City _____State _____Zip_____

Home Phone (___)_____Cell (___)_____

SS# _____ Driver's License #_____

Birthdate_____ E-mail address_____

In case of emergency, who should we notify? _____

Relationship to patient? _____ Phone_____

Who can we thank for referring you to our office?

Family/Friend (name) _____

Radio _____ TV _____ Internet _____ Other _____

EMPLOYER DATA

Name of Employer_____

Address _____

Occupation _____ Phone _____

INSURANCE DATA

Dental Insurance Company_____ Phone _____

Name of Insured_____ Insured SS#_____

Insured DOB_____ Relationship to patient _____

Employer _____Group# _____

MEDICAL DATA

Physician's Name _____ Phone #_____

Surgeries & Date _____

Do you have or have you had any of the following conditions: Yes/No

____ Anemia
____ Aneurysm
____ Asthma
____ Cancer _____
____ Diabetes
____ Emphysema/TB
____ Epilepsy
____ Heart Disorder
____ Heart Murmur
____ Heart Stent
____ Hearing Problem
____ Hepatitis
____ Internal Disorder
____ Joint Replacement-yr _____
____ Kidney/Liver Disorder
____ Lactose Intolerant
____ Mitral Valve Prolapse
____ Pacemaker
____ Rheumatic Fever
____ Stroke
____ Valve Replacement
____ Venereal Disease
____ Tested Positive to HIV

Are there any Medical Conditions not listed above? _____

Are you currently taking any ***Osteonecrosis Meds***?_____

Have you ever had an adverse reaction to anesthesia? _____

High/Low Blood Pressure (please indicate) _____

Are you currently taking ***ANY blood thinners*** such as:

Coumadin/Warfarin: _____ Plavix/Clopid_____ Eliquis _____
Heparin _____ Aspirin _____ Zeralto _____ Vitamin E _____ Other _____

Other medications you take & dosages:

_____
_____
_____

Are you ***allergic*** to:
Penicillin _____ Tetracycline _____ Codeine _____
Sulfa _____ Other allergies _____

Do you smoke? Yes_____ No_____ If yes, how much_____

Are you pregnant? _____ OB/GYN & phone#_____

DENTAL HISTORY

Y	N		Y	N	
[ ]	[ ]	Tender teeth when chewing	[ ]	[ ]	Bleeding gums
[ ]	[ ]	Senstivity to heat, cold, sweets	[ ]	[ ]	Do you grind or clench your teeth
[ ]	[ ]	Pain in or around your ears	[ ]	[ ]	Any unhealed injuries or inflamed areas in your mouth
[ ]	[ ]	Do you wish to maintain your own teeth			

The undersigned declares that he/she has examined the patient information and it is true to the best of their knowledge and is responsible for payment in full at the time services are rendered. If not paid, a 1% service charge will be affixed to all balances over 90 days.

SIGNATURE_____ Date_____

HIPPA DATA

I have read the NOTICE OF PRIVACY PRACTICES of Ackley Dental Group.

_____ _____

(signature of patient) (date)

May we call your home and leave a message on your answering machine?

[ ] YES [ ] NO

List any persons we can discuss your treatment and/or personal information with:

_____

ACKLEY DENTAL GROUP
FINANCIAL POLICY

This is an agreement between Ackley Dental Group, as creditor, and the patient/debtor named on this form. By executing this agreement, you are agreeing to pay at the time of service.

Payment options:

A. Cash
B. Check
C. Credit Card (Visa, Master Card, American Express, Discover)
D. Care Credit and Citi Healthcard—which offer 6 or 12 months interest free loans

Insurance:

Insurance is a ***contract between you and your insurance company***. We are ***NOT*** a party to this contract. We will bill your primary insurance as a courtesy to you. Although we may ***ESTIMATE*** what your insurance ***may*** pay, it is the insurance company that makes the final determination of your eligibility. ***You agree to pay any portion of the charges not covered by insurance.***

Finance Charge:

A finance charge will be imposed on your account which has not been paid within ninety days. The **FINANCE CHARGE** on your account is computed at the rate of **1.5%** per month or an annual percentage rate of 18%. The finance charge on your account is computed by applying the periodic rate (1.5%) to the overdue balance on your account.

Credit History:

You give us permission to check your credit and employment history if necessary. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Missed Appointment Fee:

Patients who miss or cancel an appointment with less than 24 hours notice will be charged a $25 per half hour fee. The fee must be paid before a new appointment is scheduled. Patient with three missed appointments will be asked to transfer their records to another office.

Past Due Accounts:

If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer your account to an attorney, you agree to pay all attorney fees which are incurred plus all court costs.

Returned Checks:

The fee for any check returned by the bank is **$25.00.**

Divorce:

In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records:

You will need to request in writing, and pay a reasonable copying fee (currently $10) if you want to have copies of your records sent to another dentist. You authorize us to include all relevant information.

Patient's name:_____

Responsible party: _____

Signature: _____ **Date:** _____