ADLER FAMILY DENTAL

Patient Information

Title: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

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

Address: _____
Street City State Zip Code

Date of Birth: _____ Gender: _____ Family Status: _____ Social Security #: _____

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

Driver's License: State_____ Number _____ Email: _____

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Responsible Party Information

The following is for the person responsible for the account.

Name: _____
Last First MI

Address: _____
Street City State Zip Code

Date of Birth: _____ Gender: _____ Family Status: _____ Social Security #: _____

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

Insurance Information

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

Insured's Birth Date: _____ Social Security #: _____ 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: _____

Authorization For Signature On File

I hereby authorize the office of Adler Family Dental to release any and all information relating to insurance claims for dental benefits. I authorize the release of all information concerning health care, diagnosis, or dental treatment provided, to any insurance company, claim administrator, or consulting health care professional.

I hereby authorize assignment of dental benefits, otherwise payable to me, directly to the office of Adler Family Dental.

I agree to be financially responsible for all charges for dental services rendered, on my behalf or my dependents, not paid by my dental benefit plan, unless there is a contractual agreement with my plan prohibiting all or a portion of such charges.

_____
Signature of Patient/Guardian Date

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient; Name _____

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

Health Information

Date of Last Dental Visit: _____ Reason for today's visit: _____

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

- ☐ Alcohol / Drug Abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints/Valves
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Cholesterol (Elevated)
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ GERD
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV+ / AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ **Pregnant**
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Disorders
- ☐ Tuberculosis (TB)
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Latex Allergy
- ☐ Penicillin Allergy
- ☐ Sulfur Allergy

OTHER:

- ☐ _____
- ☐ _____

- List all medications you are presently 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.

_____Date: _____ Signature of Dentist _____

Signature of patient, parent or guardian

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 in full at the time services are performed.

Adler Family Dental reserves the right to charge for appointments cancelled or broken without 24 hours advance notice.

I agree to be financially responsible for all charges for dental services rendered on my behalf or my dependents.

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 30 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for dental care can only be extended for a period of six months from the date of the patient examination.

I authorize the release of all information concerning health care, diagnosis, or dental treatment provided, to any insurance company, claim administrator, or consulting health care professional. I acknowledge that I have received a copy of Adler Family Dental's Notice of Privacy Practices.

I grant my permission to you or your assignee, to telephone me at home, at work or on my cellphone to discuss matters pertaining to my account.

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