Welcome

Please take a few minutes to fill out this form completely

Chart Number _____
(Office Use Only)

PLEASE PRINT LEGIBLY!!! cell

PATIENT INFORMATION email

Today's Date _____ Home phone # _____

Name _____ Soc. Sec # _____
Last Name First Name Middle Intial

Nickname _____ Address _____

City _____ State _____ Zip Code _____

Sex ( ) M ( ) F Age _____ Birthdate _____ ( ) Single ( ) Married ( ) Widowed ( ) Separated ( ) Divorced

Patient Employed by _____ Occupation _____

Business Street Address _____

Business City/Town _____ State _____ Zip Code _____

Business Telephone Number (_____) _____

If Patient is a Student, Name of School/College _____ City & State _____

Spouse's full name if married _____

Is anyone else in your house a patient here? _____ If Yes, Names _____

In Case of emergency whom should we notify? _____ Relationship _____

Emergency contact phone number _____

PRIMARY INSURANCE INFORMATION

Subscriber's Full Name _____ Relationship to patient _____

Address (if different from patient) _____
Street City State Zip Code

Home Phone _____ Business Phone _____ Occupation _____

Subscriber Employed by _____

Address _____
Street City State Zip Code

Subscriber's Birthdate _____ Soc. Sec. # _____ Insurance Phone # _____

Dental Insurance Company _____

Mailing Address for claims _____
Street City State Zip Code

Subscriber ID # or Policy # _____ Group/Union Local # _____

Members of Family covered under this policy _____

Do you have secondary insurance coverage _____ NO _____ YES If yes, name of insurance _____

PLEASE COMPLETE BOTH SIDES

DENTAL HISTORY

Reason for Today's Visit _____

Former Dentist _____ Phone _____

Date of last dental care _____ Date of last dental X-rays _____

Check (X) if you have had problems with any of the following:

( ) Bad Breath
( ) Bleeding Gums
( ) Clicking or popping jaw
( ) Food collection between teeth
( ) Grinding teeth
( ) Loose teeth or broken fillings
( ) Periodontal treatment
( ) Sensitivity to cold
( ) Sensitivity to hot
( ) Sensitivity to sweets
( ) Sensitivity when biting
( ) Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Phone # _____ Date of last visit _____

Have you had any serious illnesses or operation?( ) Yes ( ) No If yes, describe _____

Have you ever had a blood transfusion? ( ) Yes ( ) No If yes, give approximate dates _____

(Women) Pregnant or suspect pregnancy? ( ) Yes ( ) No Nursing ( ) Yes ( ) No Taking birth control pills ( ) Yes ( ) No

Check (X) if you have or have had any of the following:

( ) A.I.D.S
( ) Anemia
( ) Arthritis, Rheumatism
( ) Artificial Heart Valves
( ) Artificial Joints
( ) Asthma
( ) Back Problems
( ) Blood Disease
( ) Cancer
( ) Chemical Dependency
( ) Chemotherapy
( ) Circulatory Problems
( ) Cortisone Treatments
( ) Cough, Persistent
( ) Cough up blood
( ) Diabetes
( ) Epilepsy
( ) Fainting
( ) Glaucoma
( ) Headaches
( ) Heart Murmur
( ) Heart Problems
Describe _____
( ) Hemophilia
( ) Hepatitis
( ) High Blood Pressure
( ) HIV Positive
( ) Jaw Pain
( ) Kidney Disease
( ) Liver Disease
( ) Mitral Valve Prolapse
( ) Nervous Problems
( ) Pacemaker
( ) Psychiatric Care
( ) Radiation Treatment
( ) Respiratory Disease
( ) Rheumatic Fever
( ) Scarlet Fever
( ) Shortness of Breath
( ) Skin Rash
( ) Stroke
( ) Swelling of Feet or Ankles
( ) Thyroid Problems
( ) Tobacco Habit
( ) Tonsillitis
( ) Tuberculosis
( ) Ulcer
( ) Venereal Disease

MEDICATIONS
List medications you are currently taking:

_____
_____
_____

ALLERGIES TO MEDICATIONS

_____
_____
_____

AUTHORIZATION

I authorize my insurance company to pay to Dr. Robert B. Daniels, D.M.D. all insurance benefits otherwise payable to me for services rendered. I authorized the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I will not hold my dentist or any staff member responsible for any errors or omissions on this form.

_____ _____

Signature Date

Welcome

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PATIENT INFORMATION

Today's Date _____ Home phone # _____

Name of Minor/Child _____
Last Name First Name Middle Intial

Sex ( ) M ( ) F Age _____ Birthdate _____ Child's Social Security # _____

Home Street Address _____

City/Town _____ State _____ Zip Code _____

Person financially responsible _____ Relationship to Patient _____

PRIMARY INFORMATION / INSURANCE

Father's/Guardian's Name _____

Address (if different from patient) _____

_____

Home Phone _____ Work Phone _____

Employed _____

Address _____

_____

Soc. Sec. # _____ Birthdate _____

Do you have dental Coverage for this patient? ( ) YES ( ) NO

Dental Insurance Name _____

Insurance Phone # _____

Mailing Address for claims _____

_____

Group # of Local Union # _____

Policy # or ID # _____

Mother's/Guardian's Name _____

Address (if different from patient) _____

_____

Home Phone _____ Work Phone _____

Employed _____

Address _____

_____

Soc. Sec. # _____ Birthdate _____

Do you have dental Coverage for this patient? ( ) YES ( ) NO

Dental Insurance Name _____

Insurance Phone # _____

Mailing Address for claims _____

_____

Group # of Local Union # _____

Policy # or ID # _____

If there are two dental insurances on the minor patient, which one is the primary? _____

PLEASE COMPLETE BOTH SIDES

DENTAL HISTORY

Date of last visit to a dentist _____ For what service? _____ Date of last X-ray? _____

Has child complained about dental problems? _____ Is fluoride taken in any form? _____

Does child brush teeth daily? _____ Does child floss every day? _____

Any injuries to mouth, teeth, head? _____ Any unhappy dental experiences? _____

Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc. _____

MEDICAL HISTORY

Minor/Child's Physician _____ City & State _____ Phone _____

Date of last physical examination _____ Results _____

Is Minor/Child under care of physician now? ( ) YES ( ) NO

Receiving any medication or drugs? ( ) YES ( ) NO Medications: _____

Ever been hospitalized? ( ) YES ( ) NO _____

Ever had surgery? ( ) YES ( ) NO _____

Is there excessive bleeding when cut? ( ) YES ( ) NO Allergies: _____

_____

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE (X)

( ) A.I.D.S./H.I.V.	( ) Cerebral Palsy	( ) Epilepsy	( ) Kidney Disease	( ) Rheumatic Fever
( ) Anemia	( ) Chicken Pox	( ) Fainting	( ) Liver Disease	( ) Sinus Problems
( ) Asthma	( ) Convulsions	( ) Hearing Problems	( ) Measles	( ) Thyroid Disease
( ) Bladder Problems	( ) Diabetes	( ) Heart Problems	( ) Mononucleosis	( ) Tuberculosis
( ) Cancer	( ) Drug/Alcohol Abuse	( ) Hepatitis	( ) Mumps	( ) Other _____

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

AUTHORIZATION

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child.

I certify that my minor/child is covered by insurance with _____

Name of Insurance Company (ies)

and assign directly to Dr. Robert B. Daniels,D.M.D. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I will not hold my dentist or any staff member responsible for any errors or omissions on this form.

_____ _____

Signature Date

Financial Policy

PATIENTS WITH INSURANCE COVERAGE THAT WE PARTICIPATE WITH

We will be glad to help you obtain the appropriate benefits from your insurance carrier and bill your carrier as a courtesy to you. However, you are responsible for the payment of your account. Any applicable deductibles, estimated co-payments, procedures not covered by your insurance company and amounts that put you over your maximum yearly benefits will be collected at the time service. You will be responsible to know your insurance benefits and monitor your yearly maximum. Outstanding insurance claims not paid by your insurance carrier with a reasonable amount of time (60 days), are your responsibility and must be paid promptly by you. We will be happy to request a pre-estimate of benefits from your insurance carrier if you request us to do so. Routine treatment is generally performed without submitting a request for pre-estimate of benefits.

PATIENTS WITH INSURANCE COVERAGE THAT WE DO NOT PARTICIPATE WITH

Due to the time consuming complexities of administering insurance coverage in these plans, the patient will be responsible for submitting to their insurance company for reimbursement. A claim form will be provided. The patient is financially responsible for dental treatment at the time of service.

SECONDARY INSURANCE COVERAGE

Insurance claim form will be provided to you for submission to your secondary insurance for reimbursement to you. We do not defer collection of any balance while you submit to your secondary insurance.

PATIENTS WITHOUT INSURANCE COVERAGE

Patients without insurance coverage are financially responsible for dental treatment at the time of service. We accept cash, checks with proper I.D., Visa, MasterCard, Discover, American Express and MAC.

ADDITIONAL TERMS

Appointments are reserved time for you, therefore it is requested that you give us at least 24 hours notice (additional notice is needed for appointments longer than 40 minutes) to make any changes. Failed and changed appointments without the appropriate notice are subject to a minimum charge of $25.

Checks returned by your bank are subject to a $25 processing fee. Accounts unpaid after 60 days are subject to a finance charge at the rate of 1½% per month (18% APR). If you account is referred to a collection agency, you will be responsible for collection costs.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF THE OFFICE OF ROBERT B. DANIELS, D.M.D.

X _____ _____

Signature of Patient or Guardian **Today's Date**