Patient Information

Patient Name: ____ Date:______________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ____________

Social Security #: ______________________________ Birth Date:______________________________

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

Email:_______________________________ Preferred way of contact: ☐ Phone ☐ Text ☐ Email

Address: ____
Street Apartment #

____
City State Zip Code

Date of Last Dental Visit: ________________ Reason for this visit:_________________________________

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

☐ AIDS
☐ Allergies __________ __________
☐ Anemia
☐ Arthritis
☐ Artificial Joints______
☐ Asthma
☐ Blood Disease
☐ Bruise Easily
☐ Cancer___________
☐ Chemotherapy
☐ Cold Sores
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Fibromyalgia
☐ Glaucoma
☐ Hay Fever
☐ Head Injuries
☐ Heart Valve Replacement
☐ Heart Attack_______
☐ Heart Disease/Murmur
☐ Heart Stints
☐ Hemophilia
☐ Hepatitis A/B/C
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Psychiatric Care
☐ **Pregnancy** Due date: _________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Sickle Cell Disease
☐ Sinus Problems
☐ Seizures
☐ Stomach Problems (Colitis, Irritable bowel)
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Ulcers/Reflux
☐ Venereal Disease

☐ Snore
☐ Sleep Apnea
☐ Bruxing/Grinding
☐ Trouble Breathing
☐ Enlarged Tonsils
☐ CPAP

- 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 Explain_____________________________
- Name of Physician: ____ Phone:_________________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No Explain_______________

Are you aware of having allergic or adverse reaction to any medication or substance?____________________

Have you taken any medication or drugs during the past two years? If so please list.____________________
Are you currently taking any medications? If yes, please list.__________________________________

Name of nearest relative__________________________________Phone_____________________

Name of person to contact in case of emergency (not living with you)_______________ Phone___________

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 without fail.

____ Date:____________________
Signature of patient, parent or guardian

____ Date:____________________
Witness of Review

List of Medication

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ________________

Social Security #: ______________________________ Birth Date: ______________________________

Phone (Home): ______________ (Work): ______________ Ext: _____ Best time to call: ____________

Address: ____
Street Apartment #

____
City State Zip Code

Insurance Information

Primary

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

Insured's Birth Date: ________________ ID #: ____________________ 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__________________

Secondary

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

Insured's Birth Date: ________________ ID #: ____________________ 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__________________

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 for in cash at the time services are performed.

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.

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practices has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to the claim. I authorize payment of the dental benefits otherwise payable to me directly to the named dental entity.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. 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 be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

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

____ Date: ____________ Relationship to Patient: __________________
Witness

Referral Information

Whom may we thank for referring you to our practice? Friend/Patient?______________________

☐Yellow Pages ☐Newspaper ☐School ☐Work Other________________

Diana Tedder, DMD
P.O. Box 699
Satsuma, AL. 36572
(251) 679-9428

To Our Patients with dental insurance:

We will be happy to assist you by completing your claim forms. As a courtesy, in addition to filing the claim, we will initially ask you only for your "estimated portion" understand this is only an estimate.

The financial obligation for dental treatment is between you and our office. The insurance company is responsible to you, and not to our office. Once your carrier has paid the claim, any difference will be due upon receipt of our statement. If for any reason we have not received your insurance carrier's payment 90 days after the claim, the remaining balance will be due and payable by you.

To Our Patients who do not have dental coverage:

Our office policy is that the total amount of charges be paid at the time of service. Any other arrangements for payment must be made prior to your appointment.

Any amount due and not paid within a reasonable amount of time will be subject to interest and collection fees.

Signature: ____

Date: ____