

Is there anything else about your dental treatment that you would like us to know?

- 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 without fail.

Date: _____

Signature of patient, parent or guardian

Medications: _____

In Case of Emergency, contact:

Relationship: _____

Phone: _____

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 City State Apartment # Zip

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Dental Office Yellow Pages Newspaper School Work Other _____

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

INSURANCE INFORMATION

Primary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____
Last First MI

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: _____

Assignment and Release:

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Loving all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether payable or not payable by insurance. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize this signature on all insurance submissions.

SIGNATURE OF PATIENT (OR PARENT IF MINOR): _____

Consent for Services/Financial Guidelines

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 understand that as a courtesy to me, this office will accept insurance payments directly from the primary insurance company provided eligibility can be confirmed. I agree to handle the estimated portion that insurance is not expected to pay when treatment is started. If for some reason my insurance has not responded or paid within 60 days from the date of service, or my insurance has paid less than expected, I am responsible for the balance. Payment Options include cash or check, credit cards, and third party financing. We are happy to offer pre-payment courtesy for all treatment paid in full prior to treatment. For your convenience we accept MasterCard, Visa, American Express, and Discover. Creditworthy patients who have extended treatment may be eligible for financing.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days from date of service, unless previously written financial arrangements are satisfied.

This office does report defaulted accounts to collection agencies.

I further agree that a waiver of any breach of this consent shall not constitute a waiver of any future 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.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

HIPAA Privacy ACT; Effective April 15th 2003

It is imperative that we keep our family information up to date. Please review the following information that we have in your family file. It is imperative that addresses, phone numbers, insurance information, and marital status/dependent information is correct. If you choose to have your spousal information separated into separate files, it can be done only if insurance information is separate (you do not share the same insurance policy) or if you choose to process your own family insurance forms for reimbursement. Minors cannot be separated.

In order to comply with HIPAA regulation, we are required to verify identity and will ask for a copy of your driver's license or identification card. We also ask that you sign below that you received a copy of our Notice of Privacy Practices. We apologize for any inconveniences and hope that this new legislation puts your mind at ease.

Acknowledgement of receipt of Notice of Privacy Practices:

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature of patient (or parent if minor patient)