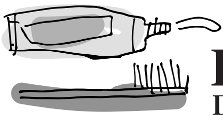

Fairview DENTAL

*smiles with style*

# WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

## 1 Patient Information

Today's Date: ______________________

Name ______________________________ Wishes to be called ______________________

Birthdate ______________________________ Soc Sec # ______________________

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Address ______________________________________________

City, State, Zip ______________________________________________

Employer ______________________ Occupation ______________________

Spouse ______________________ Spouse's Soc Sec # ______________________

Home Phone ______________________________

Work Phone ______________________ Ext # ______________________

Car Phone ______________________ Pager # ______________________

Where do you prefer to receive calls? ☐ Home ☐ Work ☐ Car ☐ Pager

When is the best time to reach you? Time ______________ Days ______________

In the event of an emergency, who is the nearest friend/family member not living with you who we may contact?

Name ______________________ Relationship ______________________

Work # ______________________ Home # ______________________

Who may we thank for referring you? ______________________________

## 2 Responsible party

Who is responsible for the account?

Name ______________________________________________

Relationship to patient ______________________________________________

Birthdate ______________________ Driver's License # ______________________

Soc Sec # ______________________________________________

Address ______________________________________________

City, State, Zip ______________________________________________

Employer ______________________ Occupation ______________________

Employer's Address ______________________________________________

City, State, Zip ______________________________________________

Work Phone ______________ Ext.# ________ Home Phone ______________

**PLEASE CONTINUE ON PAGE 2**

## 3 Dental Insurance Information

**PRIMARY INSURANCE**

Name of Insured ____________________

Relationship to Patient ____________________

Insured's Birthdate ____________________

Soc Sec # ____________________

Employer ____________________

Date Employed ____________________

Occupation ____________________

Insurance Company ____________________

Group # ____________________

Employee/Cert. # ____________________

Insurance Co. Address ____________________

Deductible ____________________

**SECONDARY INSURANCE**

Name of Insured ____________________

Relationship to Patient ____________________

Insured's Birthdate ____________________

Soc Sec # ____________________

Employer ____________________

Date Employed ____________________

Occupation ____________________

Insurance Company ____________________

Group # ____________________

Employee/Cert. # ____________________

Insurance Co. Address ____________________

Deductible ____________________

## 4 Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners.
I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.
I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

____________________________________________________________

Signature of patient, or parent if minor Date

## 5 Financial Arrangements

For your convenience, we offer the following methods of payment. Please check which option you prefer.
Payment in full at each appointment.

☐ Cash

☐ Personal Check

☐ Credit Card: ☐ Visa ☐ Mastercard ☐ Discover

☐ I wish to discuss the dental office's policy

**PLEASE CONTINUE ON PAGE 3**

## 6 Dental History

How long ago was your last dental visit? ______________________________

Why did you leave your previous dentist? ______________________________

What fears, if any, do you have of visiting a dental office? ______________________________

Why have you come in today? ______________________________

Do you have any of the following problems?

| Please check | yes | no |
|---|---|---|
| Pain with a tooth | ☐ | ☐ |
| Gum problems/Bleeding gums | ☐ | ☐ |
| Sensitivity to hot | ☐ | ☐ |
| Sensitivity to cold | ☐ | ☐ |
| Sensitivity to sweets | ☐ | ☐ |

| Please check | yes | no |
|---|---|---|
| Pain when biting (pressure pain) | ☐ | ☐ |
| Chipped or cracked teeth | ☐ | ☐ |
| Are you interested in replacing any missing teeth? | ☐ | ☐ |
| Are you happy with your smile? | ☐ | ☐ |

## 7 Medical History

Family Physician ______________________________

Address ______________________________

City, State, Zip ______________________________

Phone ______________________________

Are you in good health? Yes No (circle one)

Are you currently under a physician's care? Yes No (circle one)

If yes, for what? ______________________________

Are you taking any medication? Yes No (circle one)

If yes, what? ______________________________

Have you ever had any of the following conditions?

Heart Problems/Circulatory Problems ............ Yes No

Heart Murmur ............ Yes No

Rheumatic Fever ............ Yes No

Joint Replacement ............ Yes No

High or Low Blood Pressure ............ Yes No

Diabetes ............ Yes No

Artificial Heart Valves ............ Yes No

Hepatitis or Liver Disease ............ Yes No

Ulcers/Colitis ............ Yes No

Drug/Alcohol Abuse ............ Yes No

Nervous Disorder ............ Yes No

Psychiatric Care ............ Yes No

Tuberculosis ............ Yes No

Venereal Disease/Herpes ............ Yes No

AIDS/HIV ............ Yes No

Kidney or Renal Problems ............ Yes No

Cancer/Chemotherapy/Radiation Therapy...... Yes No

Mitral Valve Prolapse ............ Yes No

Thyroid ............ Yes No

Sinus Problems ............ Yes No

Hay Fever ............ Yes No

Allergies ............ Yes No

Asthma ............ Yes No

Bleeding or Clotting Problems/Hemophilia.... Yes No

Recent Hospitalization ............ Yes No

If yes, for what? ______________________________

Are you pregnant? ............ Yes No

If yes, your due date is ______________________________

Do you smoke? ............ Yes No

Do you use chewing tobacco? ............ Yes No

Are you allergic to any of the following:

Penicillin ............ Yes No

Sulfa Drugs ............ Yes No

Aspirin ............ Yes No

Codeine ............ Yes No

Dental Anesthetics ............ Yes No

Antibiotics ............ Yes No

Latex ............ Yes No

Other ______________________________

**Signature** **Date**

PLEASE CONTINUE ON PAGE 4

## Our Financial Policy

Patients are expected to pay by cash, check or credit card the day the service is rendered unless specific arrangements have been made in advance with the financial secretaries.

For those patients who are covered by insurance, we will accept assignments of benefits. This means that you must sign the portion of your insurance form that "assigns" payment to our office. Most insurance plans do not cover 100% of the cost of treatment. You are expected to pay your deductible and your portion of the estimated charges the day the services are rendered. We will ESTIMATE as closely as possible your coverage, but until we actually receive payment from the insurance company, **it is just an estimate**. We will assist you in dealing with your insurance company, but the ultimate responsibility lies with you.

All accounts with a balance over 90 days old will be accessed a monthly service charge of 1.5% of the balance. In addition an "Administration Fee" of 50% of the outstanding balance will be added to any account past 90 days old being turned over to our collection agency or attorney. The responsible party of the account will be responsible for all Court cost and reasonable attorney fees.

Feel free to ask any questions that remain unanswered either before or after treatment.

Sincerely,

Gary L. Ahasic, D.M.D.
Laurence A. Sexton, D.D.S.
Brian R. Tonner, D.D.S.
Michele L. Bruno, D.D.S.

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**I understand and agree to the above financial policy. I acknowledge I have reviewed a copy of this office's notice of privacy practices. (HIPPA)**

Responsible party's signature ______________________ Date ____________