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: _____

Legal Name _____ Preferred Name _____

Birthdate _____ Soc Sec # _____

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

Home Address _____

City, State, Zip _____

Employer _____ Occupation _____

Home Phone _____

Work Phone _____ Ext # _____

Cell Phone _____ E-Mail Address _____

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?

Relationship to patient ☐ self (same as above) ☐ spouse ☐ Parent/Guardian ☐ other _____

Name _____

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 ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Dependent ☐ other _____

Insured's Birthdate _____

Insured's Address _____

Insured's Phone _____

Soc Sec # _____

Employer _____

Insurance Company _____

Group # _____

Member ID # _____

SECONDARY INSURANCE

Name of Insured _____

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Dependent ☐ other _____

Insured's Birthdate _____

Insured's Address _____

Insured's Phone _____

Soc Sec # _____

Employer _____

Insurance Company _____

Group # _____

Member ID # _____

4 Authorization and Release

I acknowledge I have reviewed a copy of Fairview Dental's notice of privacy practices. (HIPPA)

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.

X _____

Signature of patient, or parent if minor Date

5 Payment Options

For your convenience, we offer the following methods of payment:

- Cash
- Personal Check
- Visa, Mastercard and Discover
- Care Credit® with no interest[1] Payment Plans[2]
  - Allow you to pay over time with no interest[1]
  - Convenient, low monthly payment plans[2] also available
  - No annual fees or pre-payment penalties

[1] If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment rrequired.

[2] Subject to credit approval.

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	Please check	yes	no
Pain with a tooth	☐	☐	Pain when biting (pressure pain)	☐	☐
Gum problems/Bleeding gums	☐	☐	Chipped or cracked teeth	☐	☐
Sensitivity to hot	☐	☐	Are you interested in replacing any missing teeth?	☐	☐
Sensitivity to cold	☐	☐	Are you happy with your smile?	☐	☐
Sensitivity to sweets	☐	☐			

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	Sinus Problems	Yes	No
Heart Murmur	Yes	No	Hay Fever	Yes	No
Rheumatic Fever	Yes	No	Allergies	Yes	No
Joint Replacement	Yes	No	Asthma	Yes	No
High or Low Blood Pressure	Yes	No	Bleeding or Clotting Problems/Hemophilia	Yes	No
Diabetes	Yes	No	Recent Hospitalization	Yes	No
Artificial Heart Valves	Yes	No	If yes, for what? _____		
Hepatitis or Liver Disease	Yes	No	Are you pregnant?	Yes	No
Ulcers/Colitis	Yes	No	If yes, your due date is _____		
Drug/Alcohol Abuse	Yes	No	Do you smoke?	Yes	No
Nervous Disorder	Yes	No	Do you use chewing tobacco?	Yes	No
Psychiatric Care	Yes	No	Are you allergic to any of the following:		
Tuberculosis	Yes	No	Penicillin	Yes	No
Venereal Disease/Herpes	Yes	No	Sulfa Drugs	Yes	No
AIDS/HIV	Yes	No	Aspirin	Yes	No
Kidney or Renal Problems	Yes	No	Codeine	Yes	No
Cancer/Chemotherapy/Radiation Therapy	Yes	No	Dental Anesthetics	Yes	No
Mitral Valve Prolapse	Yes	No	Antibiotics	Yes	No
Thyroid	Yes	No	Latex	Yes	No
			Other _____		

X _____

Signature of patient, or parent if minor Date

PLEASE CONTINUE ON PAGE 4

Our Financial Policy

Your treatment plan is based on your dental needs, not on your insurance coverage. **You are responsible for all fees for services provided.** If you are concerned about Fairview Dental's fees for any treatment, please notify the doctor or office manager immediately. As a patient, you do have the right to refuse any of the recommended treatment for your own personal reasons.

INSURANCE: Payment will be due by you at the time of service for non-covered services, deductibles, or co-pays. If you have a deductible that has not been met, we will collect the full amount of fees for services up to your deductible amount. Any fees collected exceeding the amount you are responsible for will be applied to future visits, credited to your account, or refunded upon request when there are no outstanding balances on your account.

For those patients who are covered by insurance, we will accept assignments of benefits with the exclusion of Orthodontic treatment. This means you must sign the portion of this form that "assigns" payment to our office. We will ESTIMATE as closely as possible your coverage, but until we actually receive payment from the insurance company, it is just an estimate. Your insurance policy is a contract between you and your insurance company. Fairview Dental has no authority over your benefits or coverage. While Fairview Dental does its best to work with your insurance company, the benefits quoted to us by your insurance company are not a guarantee of payment, and if your insurance denies payment for services you have received, you are ultimately responsible for all fees for those services provided.

All accounts with a balance over 90 days will be accessed a monthly service charge of 1.5% of the balance. I understand that if my account is referred to a collection agency, I will be responsible for all collection fees of (50%) of the unpaid balance and reasonable attorney fees of one third (1/3) of the balance referred to the attorney.

*I have read and understand all of the information contained in this payment policy. All of my questions have been answered to my satisfaction. To the best of my knowledge, the information I have provided is true and accurate. I understand that I am ultimately responsible for paying for any service that I receive from Fairview Dental and its employees.

X

Signature of patient, or parent if minor Date

Nuestra Póliza Financiera

Su plan de tratamiento está basado en sus necesidades dentales, no según lo que cubre su aseguranza. **Usted es responsable de pagar por cualquier servicio proporcionado.** Si usted tiene alguna duda sobre los cobros de tratamiento de Fairview Dental, por favor, avísele al dentista o al gerente de la oficina inmediatamente. Como paciente, usted tiene el derecho de rehusar cualquier tratamiento recomendado por sus propias razones personales.

ASEGURANZA: Usted deberá pagar el mismo dia del tratamiento por servicios no cubiertos, deducibles, y co-pagos. Si usted tiene un deducible que no se ha cumplido, cobraremos por todos los servicios hasta que se haya cumplido su deducible. Cualquier pago colectado que sume más de la cantidad por la que usted es responsable será aplicado a futuras visitas, acreditado a su cuenta, o devuelto a petición, cuando no haya saldos pendientes en en su cuenta.

Para los pacientes que tienen aseguranza, aceptaremos los beneficios asignados menos el tratamiento ortodóntico. Esto significa que usted debe firmar la porción de este formulario que indica el pago a nuestra oficina. Nosotros estimaremos lo más cerca posible su cobertura, pero, hasta que recibamos el pago actual de su aseguranza, será solamente un estimado. Su aseguranza es un contrato entre usted y su compañía de aseguranza. Fairview Dental no tiene autoridad sobre sus beneficios o cobertura. Aunque Fairview Dental hace lo mejor possible por trabajar con su compañía de aseguranza, los beneficios citados por su compañìa de aseguranza no son garantia de pago, y si su aseguranza rechaza pagar por servicios que usted ha recibido, usted será responsable de pagar esos servicios en su totalidad.

Todas las cuentas con un saldo de más de 90 días, tendran un cargo mensual de 1.5% del saldo. Yo entiendo que si mi cuenta se refiere a una agencia de colección, yo seria responsable de todas las tarifas de cobro sobre el saldo impagado (50%) y los honorarios del abogado de un tercio del saldo a que se refiere el abogado.

*He leído y entiendo toda la información contenida en esta póliza de pagos. Todas mis preguntas han sido contestadas a mi satisfacción. Según mi conocimiento, la información que yo he proporcionado es correcta. Yo comprendo que soy responsable en última instancia por el pago de cualquier servicio que he recibido de Fairview Dental y sus empleados.

X

Firma de paciente o padre de menor Fecha