PATIENT UPDATE

Please fill out the **front and back** of this form and return to the front desk when you are done. **Incomplete information** may cause a delay in billing procedures causing you to be responsible for interest and late charges.

PATIENT_____
Last Name First Name Middle Initial

ADDRESS_____
Street City Zip

HOME #_____ WORK #_____ CELL #_____

EMAIL:_____ BIRTHDATE_____

EMPLOYER_____ OCCUPATION_____

How do you prefer to be contacted? □Phone □Text □Email

DENTAL INSURANCE

EMPLOYEE NAME_____ EMPLOYER_____

INSURANCE COMPANY_____ GROUP #_____

ID#_____ EMPLOYEE SS#_____EMPLOYEE BIRTHDATE_____

PATIENT RELATIONSHIP TO EMPLOYEE: □SELF □SPOUSE □CHILD □OTHER

IS PATIENT A FULL TIME STUDENT?_____ SCHOOL_____

MEDICAL HISTORY

1) Please list any medications (Prescription and Over the Counter) that you are currently taking:_____
_____

2) Please list all medications that you are allergic to_____
_____

3) Circle any of the following which you have had or have at the present:

Diabetes	Heart Murmur	Joint Replacement	Hepatitis
AIDS	High Blood Pressure	Heart Disease	Cancer
Epilepsy	Heart Pacemaker	Psychiatric Treatment	

4) Have you ever taken any of the following medications? If so, for how long?_____

Actonel/Boniva	Fosamax	Fosamax Plus D	Skelid
Didronel	Aredia*	Zometa*	Bonefos*

PATIENT SIGNATURE:_____ DATE:_____

FINANCIAL POLICIES

1) We will **not** file secondary insurance.

2) A 1 ½ % finance charge (18% annually) will be added to **any** balance over 60 days. It is the patient's responsibility to provide **accurate** insurance and billing information. **The finance charge will not be removed due to inaccurate information.** It is the patient's responsibility to inform us of any changes in their insurance policy, billing address, and phone number.

3) After 60 days of non-payment, the patient's account will be transferred to a recovery agency. Once transferred the patient is responsible not only for their bill, but all collection costs and attorney fees.

4) There is a $25 charge for all appointments cancelled without 24 hours notice.

The information provided on this form is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I understand my signature will be used as a "signature on file" for insurance processing. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made.

Patient Signature:_____ Date:_____

Printed Name:_____ Relationship to Patient:_____

EMERGENCY CONTACT INFORMATION:

Name:_____ **Phone #**_____