Patient Information Sheet

Patient Name_____ **Today's Date:**_____

Address _____City_____ Zip_____

Cell # _____ Work # _____ext._____Other #_____

Sex M F Birthdate _____ Age _____ SS# _____ Marital Status _____

Dental Insurance _____ Subscriber's Name _____DOB:_____

AHCCCS ID #A_____ Employer _____

Member ID#, Employer ID#, SS#_____ Group # _____ Telephone # _____

Responsible Party _____ Relationship to patient _____
(if Patient is 18 and under)

Whom may we thank for referring you to our office? _____

Dental History

Reason for today's visit _____

Date of last dental visit _____ Date of last X-rays _____ Periodontal treatment _____

Please indicate if any of the following conditions pertain to you:

- ☐Bad breath
- ☐Broken teeth/fillings
- ☐Burning sensation on tongue
- ☐Food collection in teeth
- ☐Grinding teeth
- ☐Jaw pain, clicking or popping
- ☐Periodontal treatment
- ☐Swollen/ tender / bleeding gums
- ☐Tobacco habit
- ☐Sensitivity to cold / hot/ sweets
- ☐Sensitive when biting
- ☐Sores/Growth in mouth

How often do you floss? _____ How often do you brush? _____

Health History

Please indicate if you have had any of the following:

- ☐AIDS/HIV
- ☐Anemia
- ☐Arthritis
- ☐Artificial Heart Valves
- ☐Artificial Joints
- ☐Asthma
- ☐Back Problems
- ☐Blood Disease
- ☐Cancer
- ☐Chemical Dependency
- ☐Chemotherapy
- ☐Circulatory Problems
- ☐Cortisone Treatments
- ☐Cough, persistent
- ☐Diabetes
- ☐Dizziness
- ☐Emphysema
- ☐Epilepsy
- ☐Fainting
- ☐Glaucoma
- ☐Headaches
- ☐Heart Lesions
- ☐Heart Murmur
- ☐Heart Problems
- ☐Hepatitis Type ___
- ☐Herpes
- ☐High Blood Pressure
- ☐Kidney Disease
- ☐Mitral Valve Prolapse
- ☐Nervous Problems
- ☐Pacemaker
- ☐Psychiatric Care
- ☐Radiation Therapy
- ☐Respiratory Disease
- ☐Scarlet Fever
- ☐Shortness of Breath
- ☐Sinus trouble
- ☐STD
- ☐Stroke
- ☐Thyroid Problems
- ☐Tonsillitis
- ☐Tuberculosis
- ☐Tumor or Growth
- ☐Ulcer

Women: Are you Pregnant? _____ → if *Yes*, how many weeks_____ Nursing? _____

Taking birth control pills? _____ ALLERGIES: _____

MEDICATIONS: _____

Emergency Contact

In Case of Emergency, Contact _____ Relationship to patient_____

Cell # _____ Work # _____ Home #_____

Signature of Patient, Parent or Guardian _____ Date _____

Please print name of Patient, Parent or Guardian _____ Relationship to Patient _____

Financial Policies and Payment Options

We have several financial policy options available for your convenience. We have found that our patients appreciate knowing exactly what financial responsibilities they will incur. Therefore, we inform our patients about our financial policies before we begin treatment. Our office accepts **Cash**, **Check**, Major Credit Cards (including **Visa**, **MasterCard**, **Discover**, and **American Express**), and **Care Credit**.

***All returned checks will be subject to a $35 fee**
which will automatically adjusted on to your account.

Dental Insurance

As a courtesy to you, we do accept assignment of benefit payments from most insurance companies. To do this, we **estimate** each parties' portion based on limited information obtained from yourself and your insurance company. **Any portion estimated to be your responsibility is due either before or at the time of service**. Please understand that even the best insurance companies do not cover 100% of all dental expenses. The amount of your insurance company's payment is determined by the level of coverage purchased by you and/or your employer. Your dental insurance is your responsibility.

In order for us to assist you with your insurance, all insurance information must be provided to our office before treatment is to be performed or we reserve the right to postpone appointments until such information is received.

It is your responsibility to notify us of any changes in your dental insurance. Any charges for treatment performed before insurance eligibility begins or after it terminates will be adjusted to reflect our office fees and not discounted insurance fees.

We allow up to 90 days for your insurance company to make payment. After this time payment is due by you and it becomes your responsibility to seek reimbursement from your insurance company.

I certify that I, and/or my dependent(s), have **insurance** coverage with _____ and assign directly to **Dr. Hilarry A. Douglas** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent shall remain current for the duration of my treatment at the above-named office.

I have read and understand all of the financial policies as stated above.

_____ _____
Signature of Patient, Parent or Guardian Date

_____ _____
Print name of Patient, Parent or Guardian Relationship to Patient

HILARRY A. DOUGLAS, D.D.S., P.C.

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

I, _____, have received the Notice of Privacy Practices and have been provided an opportunity to review it.

Name of Patient: _____Relationship_____

Signature:_____Today's Date:_____