TO BE COMLETED BY OFFICE

LAST NAME

FIRST NAME

	DATE			INITIALS
PHOTO				
MEDICAL				
EXISTING				
PERIO				
TREATMENT PLAN				
INSURANCE				
SCANNED				

**********PATIENT INFORMATION**********

**********PLEASE PRINT**********

TODAY'S DATE

PATIENT'S SOCIAL SECURITY # | AGE | PATIENT'S DATE OF BIRTH

LAST NAME | FIRST NAME | MIDDLE INITIAL

ADDRESS | CITY | STATE | ZIP

HOME PHONE | CELL OR PAGER # | DAYTIME NUMBER

EMPLOYER NAME | OCCUPATION

EMPLOYER ADDRESS | CITY | STATE | ZIP

MARITAL STATUS | HEIGHT | WEIGHT | SEX

EMERGENCY CONTACT NAME | PHONE NUMBER | RELATIONSHIP

PHYSICIANS NAME | PHONE NUMBER

PLEASE LIST CURRENT MEDICAL CONDITIONS YOU ARE BEING TREATED FOR

LIST ANY MEDICATIONS YOU ARE TAKING

LIST ALL DRUG ALLERGIES

DATE AND REASON FOR LAST PHYSICAL

	YES	NO	DATE		YES	NO	DATE
Rheumatic Fever/Heart Defect				Abnormal Bleeding / Poor Clotting			
Heart Attack in the past 6 months				Epilepsy / Seizure			
Heart Surgery/Pace Maker				Tuberculosis			
High Blood Pressure (Hypertension)				Lung Disease / Emphysema / Asthma			
AIDS or ARC				Cancer / Tumors			
Angina / Chest Pain				Anemia			
Hepatitis A / B / C or Liver Disease				Nervous / Psychiatric Problems			
Hepatitis B Antigen Test*				Special Diets			
Diabetes				Major Operations			
Goiter / Thyroid Disorder				Intestinal Problems			
Drug Dependency				Women: Are You Pregnant?			
				Any Other Not Mentioned Above			

*If you have a history of Hepatitis B we may need a blood test to rule out carrier status

PREVIOUS DENTIST NAME AND PHONE # _____

PAST TREATMENT OF THE MOUTH, JAW OR FACE? _____

ANY PROBLEMS WITH PREVIOUS DENTAL TREATMENT? _____

ORTHODONTIC TREATMENT (BRACES OR RETAINERS? _____

ANY CURRENT DENTAL PROBLEMS?

INSURANCE/FINANCIAL POLICY

TODAY'S DATE: _____

PATIENT NAME: _____

LAST **FIRST**

INSURANCE INFORMATION

WHO IS THE EMPLOYEE WITH THE INSURANCE? _____

HOW ARE YOU RELATED TO THE INSURED? _____

WHO IS THEIR EMPLOYER? _____

WHAT IS THEIR SOCIAL SECURITY #? _____

WHAT IS THEIR DATE OF BIRTH? _____

WHAT IS THE NAME OF THE INSURANCE COMPANY? _____

WHAT IS THE INSURANCE COMPANIES PHONE #? _____

FINANCIAL POLICY

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE. If you have insurance we will collect your co-payment at the time services are performed. As a courtesy to you, we will file a claim to your insurance company.

YOU ARE RESPONSIBLE FOR ALL AMOUNTS THAT YOUR INSURANCE DOES NOT PAY. We accept MC, VISA, Discover, AMEX, cash and local checks.

CANCELLATION POLICY

We require a 24-hour cancellation notice. A $25.00 FEE PER SCHEDULED HOUR will be applied to your account when you cancel without 24-hour notice.

COLLECTION POLICY

Accounts should be paid in full within 60 days. ACCOUNTS WITH A BALANCE OVER 90 DAYS WILL BE CHARGED 1-1/2% INTEREST PER MONTH FOR EACH MONTH THE ACCOUNT IS PAST DUE.

If you fail to pay for your treatment and collection procedures are required, YOU ARE RESPONSIBLE FOR ALL COSTS OF COLLECTION UP TO 40% OF THE UNPAID BALANCE. These fees include but are not limited to reasonable attorney fees.

WRITTEN AUTHORIZATION AND AGREEMENT

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to be made to John K. Dooley, D.D.S..

PRIVACY POLICY

Our practice complies with the Health Insurance Portability and Accountability Act. Your medical records are private and only the necessary information will be used to complete your treatment and collect payment.
For a complete copy of the HIPPA act g http://www.hhs.gov/ocr/hippa/finalreg.html

I hereby certify that I have fully read the above and agree with all terms and conditions.

Signature of Patient, Parent or Guardian _____

Thank you for your cooperation,

Dr. John K. Dooley