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 48-hour cancellation notice. A $50.00 FEE PER SCHEDULED HOUR will be applied to your account when you cancel without 48-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