

AccuCare Dental Centers, PC

Health History

NAME: _____ Male Female
 First Middle Last Date of Birth

- 1) Reason for today's visit? _____
- 2) When was your last visit to a dentist? What was it for? _____
- 3) Are you having pain or discomfort at this time? Yes No
- 4) Do you feel very nervous about having dental treatment? Yes No
- 5) Have you ever had a bad experience in a dental office? Yes No
- 6) Have you been under the care of a physician during the last two years? Yes No
 Physician's Name _____
 Address _____
 Phone Number _____
- 7) Are you now taking any medications, drugs, pills or use tobacco? Yes No
 If yes, please list _____
- 8) Are you allergic to or have you reacted adversely to any medications or substances?

<input type="checkbox"/> Yes <input type="checkbox"/> No Aspirin	<input type="checkbox"/> Yes <input type="checkbox"/> No Codeine	<input type="checkbox"/> Yes <input type="checkbox"/> No Other
<input type="checkbox"/> Yes <input type="checkbox"/> No Penicillin	<input type="checkbox"/> Yes <input type="checkbox"/> No Erythromycin	If yes, please list _____
<input type="checkbox"/> Yes <input type="checkbox"/> No Local Anesthetic	<input type="checkbox"/> Yes <input type="checkbox"/> No Latex	
- 9) Have you ever been a patient in a hospital? Yes No
 If yes, indicate procedures performed _____
- 10) Have you in the past or do you currently have:

<input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease/Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No TMJ Treatment
<input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes
<input type="checkbox"/> Yes <input type="checkbox"/> No Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric Treatment
<input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No HIV+
<input type="checkbox"/> Yes <input type="checkbox"/> No Heart Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis B (serum)
<input type="checkbox"/> Yes <input type="checkbox"/> No Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No Pain in Jaw Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No Drug Addiction
- 11) Do you have any disease, condition or problem that is not listed? Yes No
 If yes, please describe _____
- 12) For women only:
 Are you taking birth control pills? Yes No
 Are you pregnant? Yes No
 If yes, what month? _____

CONSENT: To the best of my knowledge, the above information on this Health History sheet is as complete and accurate as possible. I understand that without full and accurate information the Doctor may not be able to provide me with the best care possible. I hereby authorize the Doctor to take radiographs (X-rays), study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of my dental needs. Also, by presenting myself for treatment, I authorize the Doctor to perform any and all forms of treatment, medication & therapy, which may be indicated and I further authorize and consent that the Doctor choose and use such assistance as he/she deems fit.

 Signature of Patient (or Responsible Party)

 Date

 Health History Reviewed by Provider

 Date

AccuCare Dental Centers, PC

Account Information

PATIENT INFORMATION

NAME:	First	Middle	Last	Date of Birth	Social Security Number
ADDRESS: Street	City	State	Zip Code	Marital Status	
TELEPHONE NUMBERS:	Home	Work or School	Cellular	E-Mail Address	

RESPONSIBLE PARTY INFORMATION (if patient is not the responsible party)

NAME:	First	Middle	Last	Date of Birth	Social Security Number
ADDRESS: Street	City	State	Zip Code	Relationship to Patient	
TELEPHONE NUMBERS:	Home	Work or School	Cellular	E-Mail Address	

INSURANCE INFORMATION

NAME:	First	Middle	Last	Date of Birth	Social Security Number
ADDRESS: Street	City	State	Zip Code	Relationship to Patient	
TELEPHONE NUMBERS:	Home	Work or School	Cellular	E-Mail Address	
INSURANCE COMPANY:	Name	Address	Tel	phone Number	
EMPLOYER:	Name	Address	Tel	phone Number	
INSURANCE NUMBERS:	Group	Patient's Insurance ID Number	Policy Number		

AccuCare Dental Centers, PC

Financial & Other Policies

Thank you for choosing us as your dental health care provider. We are committed to your treatment being successful. Please understand that payment for services rendered part of your treatment. The following is a statement of AccuCare Dental Centers, PC's Financial & Other Policies which needs to be read and signed before seeing the Doctor &/or beginning any treatment.

Payment: Payment of all of patient's estimated co-payments &/or deductibles are due at check in prior to services being rendered. Payment may be made with; cash, check, VISA, MasterCard, debit card or by 3rd party financing.

Dental Insurance/Plan: We work with most dental insurance/plans. We will attempt to help you determine what your dental insurance/plan benefits are, based on the information that you and the company provide to us. Your dental insurance/plan policy is a contract between you and your dental insurance/plan. We are not party to that contract, and therefore cannot accept any responsibility for the accuracy of the discounted fees, co-payments, deductibles or other dental insurance/plan benefits. If you require a binding fee estimate or pre-determination of benefits prior to treatment it must come from your dental insurance/plan.

As mentioned above, all estimated co-payments &/or deductibles are required to be paid prior to service. Any remaining balance is your responsibility whether the dental insurance/plan covers and pays for the service or not. We are only able to successfully bill the dental insurance/plan on your behalf if given complete and accurate insurance information and an original claim form. You authorize us to release any & all information necessary to secure payment of benefits and to use your signature below on all dental insurance/plan submissions.

If your dental insurance/plan has not paid your account in full within 60 days of rendering services, you hereby agree that you are required to immediately pay the complete remaining balance. Any payments received by us by the dental insurance/plan after this time will be forwarded to you.

In the event that your dental insurance/plan coverage changes or does not cover your treatment, you will be billed our usual and customary fees for the services rendered. Therefore, it is extremely important that you keep us updated of any changes in your dental insurance/plan.

Usual and Customary Fees: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for this payment regardless of any dental insurance/plan's arbitrary determination of usual and customary fees. Additionally please be aware that some of the services provided may not be considered by your dental insurance/plan to be covered services &/or reasonable and necessary.

Past Due Balances: A 1½% billing charge per month (18% annually, \$1.50/month minimum) will be added to any balance after completion of planned treatment. In the event of default, you promise to pay the balance, any legal interest on the indebtedness, together with such reasonable collection costs and attorney fees as may be required to collect the entire balance.

Returned Checks: There is a fee (currently \$35.00) for any checks returned by the bank.

Missed Appointments: Unless appointments are canceled or rescheduled at least 48 hours in advance, our policy is to dismiss patients that miss two appointments from the practice. Some dental insurance/plans also have built in charges to be paid by the patient for missed appointments (some up to \$80.00). Please help us serve you and all our patients better by keeping scheduled appointments.

I certify that I (or my dependent) have dental insurance/plan coverage as indicated and assign directly to AccuCare Dental Centers, PC all insurance benefits otherwise payable to me for services rendered. I have been given a read copy of AccuCare Dental Centers, PC's (i) Financial & Other Policies and (ii) Notice of Privacy Practices forms and that I understand and agree to all of the terms.

Signature of Patient (or Responsible Party)

Date