

PATIENT INFORMATION

CONFIDENTIAL

DATE _____

(PLEASE PRINT)

NAME _____ BIRTHDATE _____ HOME PHONE _____
FIRST MI LAST

ADDRESS _____ CITY _____ STATE _____ ZIP _____

E-MAIL _____ CELL PHONE _____

CHECK APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED
PATIENT'S OR PARENT/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____
SPOUSE OR PARENT/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____ CITY _____ STATE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

E-MAIL _____ CELL PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

X
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR _____

DATE _____

MEDICAL HISTORY

PHYSICIAN NAME _____ PHONE NUMBER _____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY YOU WILL RECEIVE. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

- ARE YOU UNDER A PHYSICIAN'S CARE NOW? YES NO If yes, please explain: _____
- HAVE YOU EVER BEEN HOSPITALIZED OR HAD A MAJOR OPERATION? YES NO If yes, please explain: _____
- HAVE YOU EVER HAD A SERIOUS HEAD OR NECK INJURY? YES NO If yes, please explain: _____
- ARE YOU TAKING ANY MEDICATIONS, PILLS, OR DRUGS? YES NO If yes, please explain: _____
- DO YOU TAKE, OR HAVE YOU TAKEN, PHEN-FEN OR REDUX? YES NO _____
- ARE YOU ON A SPECIAL DIET? YES NO _____
- DO YOU USE TOBACCO? YES NO _____
- DO YOU USE CONTROLLED SUBSTANCES? YES NO _____

WOMEN: ARE YOU _____

PREGNANT/TRYPING TO GET PREGNANT? YES NO Taking oral contraceptives? YES NO Nursing? YES NO

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? _____

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: _____

- DO YOU HAVE OR HAVE YOU HAD, ANY OF THE FOLLOWING? _____
- | | | | | | |
|---------------------------|--|---------------------------|--|----------------------------|--|
| AIDS/HIV Positive | <input type="radio"/> YES <input type="radio"/> NO | Excessive Bleeding | <input type="radio"/> YES <input type="radio"/> NO | Lung Disease | <input type="radio"/> YES <input type="radio"/> NO |
| Alzheimer's Disease | <input type="radio"/> YES <input type="radio"/> NO | Excessive Thirst | <input type="radio"/> YES <input type="radio"/> NO | Mitral Valve Prolapse | <input type="radio"/> YES <input type="radio"/> NO |
| Anaphylaxis | <input type="radio"/> YES <input type="radio"/> NO | Fainting Spells/Dizziness | <input type="radio"/> YES <input type="radio"/> NO | Pain in Jaw Joints | <input type="radio"/> YES <input type="radio"/> NO |
| Anemia | <input type="radio"/> YES <input type="radio"/> NO | Frequent Cough | <input type="radio"/> YES <input type="radio"/> NO | Parathyroid Disease | <input type="radio"/> YES <input type="radio"/> NO |
| Angina | <input type="radio"/> YES <input type="radio"/> NO | Frequent Diarrhea | <input type="radio"/> YES <input type="radio"/> NO | Psychiatric Care | <input type="radio"/> YES <input type="radio"/> NO |
| Arthritis/Gout | <input type="radio"/> YES <input type="radio"/> NO | Frequent Headaches | <input type="radio"/> YES <input type="radio"/> NO | Radiation Treatments | <input type="radio"/> YES <input type="radio"/> NO |
| Artificial Heart Valve | <input type="radio"/> YES <input type="radio"/> NO | Genital Herpes | <input type="radio"/> YES <input type="radio"/> NO | Recent Weight Loss | <input type="radio"/> YES <input type="radio"/> NO |
| Artificial Joint | <input type="radio"/> YES <input type="radio"/> NO | Glaucoma | <input type="radio"/> YES <input type="radio"/> NO | Renal Dialysis | <input type="radio"/> YES <input type="radio"/> NO |
| Asthma | <input type="radio"/> YES <input type="radio"/> NO | Hay Fever | <input type="radio"/> YES <input type="radio"/> NO | Rheumatic Fever | <input type="radio"/> YES <input type="radio"/> NO |
| Blood Disease | <input type="radio"/> YES <input type="radio"/> NO | Heart Attack/Failure | <input type="radio"/> YES <input type="radio"/> NO | Rheumatism | <input type="radio"/> YES <input type="radio"/> NO |
| Blood Transfusion | <input type="radio"/> YES <input type="radio"/> NO | Heart Murmur | <input type="radio"/> YES <input type="radio"/> NO | Scarlet Fever | <input type="radio"/> YES <input type="radio"/> NO |
| Breathing Problem | <input type="radio"/> YES <input type="radio"/> NO | Heart Pace Maker | <input type="radio"/> YES <input type="radio"/> NO | Shingles | <input type="radio"/> YES <input type="radio"/> NO |
| Bruise Easily | <input type="radio"/> YES <input type="radio"/> NO | Heart Trouble/Disease | <input type="radio"/> YES <input type="radio"/> NO | Sickle Cell Disease | <input type="radio"/> YES <input type="radio"/> NO |
| Cancer | <input type="radio"/> YES <input type="radio"/> NO | Hemophilia | <input type="radio"/> YES <input type="radio"/> NO | Sinus Trouble | <input type="radio"/> YES <input type="radio"/> NO |
| Chemotherapy | <input type="radio"/> YES <input type="radio"/> NO | Hepatitis A | <input type="radio"/> YES <input type="radio"/> NO | Spina Bifida | <input type="radio"/> YES <input type="radio"/> NO |
| Chest Pains | <input type="radio"/> YES <input type="radio"/> NO | Hepatitis B or C | <input type="radio"/> YES <input type="radio"/> NO | Stomach/Intestinal Disease | <input type="radio"/> YES <input type="radio"/> NO |
| Cold Sores/Fever Blisters | <input type="radio"/> YES <input type="radio"/> NO | Herpes | <input type="radio"/> YES <input type="radio"/> NO | Stroke | <input type="radio"/> YES <input type="radio"/> NO |
| Congenital Heart Disorder | <input type="radio"/> YES <input type="radio"/> NO | High Blood Pressure | <input type="radio"/> YES <input type="radio"/> NO | Swelling of Limbs | <input type="radio"/> YES <input type="radio"/> NO |
| Convulsions | <input type="radio"/> YES <input type="radio"/> NO | Hives or Rash | <input type="radio"/> YES <input type="radio"/> NO | Thyroid Disease | <input type="radio"/> YES <input type="radio"/> NO |
| Cortisone Medicine | <input type="radio"/> YES <input type="radio"/> NO | Hypoglycemia | <input type="radio"/> YES <input type="radio"/> NO | Tonsillitis | <input type="radio"/> YES <input type="radio"/> NO |
| Diabetes | <input type="radio"/> YES <input type="radio"/> NO | Irregular Heartbeat | <input type="radio"/> YES <input type="radio"/> NO | Tuberculosis | <input type="radio"/> YES <input type="radio"/> NO |
| Drug Addiction | <input type="radio"/> YES <input type="radio"/> NO | Kidney Problems | <input type="radio"/> YES <input type="radio"/> NO | Tumors or Growths | <input type="radio"/> YES <input type="radio"/> NO |
| Easily Winded | <input type="radio"/> YES <input type="radio"/> NO | Leukemia | <input type="radio"/> YES <input type="radio"/> NO | Ulcers | <input type="radio"/> YES <input type="radio"/> NO |
| Emphysema | <input type="radio"/> YES <input type="radio"/> NO | Liver Disease | <input type="radio"/> YES <input type="radio"/> NO | Veneral Disease | <input type="radio"/> YES <input type="radio"/> NO |
| Epilepsy or Seizures | <input type="radio"/> YES <input type="radio"/> NO | Low Blood Pressure | <input type="radio"/> YES <input type="radio"/> NO | Yellow Jaundice | <input type="radio"/> YES <input type="radio"/> NO |

HAVE YOU EVER HAD ANY SERIOUS ILLNESS NOT LISTED ABOVE? YES NO If yes, please explain: _____

COMMENTS: _____

TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS FORM HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY (OR PATIENT'S) HEALTH. IT IS MY RESPONSIBILITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES IN MEDICAL STATUS.

SIGNATURE OR PATIENT, PARENT, OR GUARDIAN _____ DATE _____

FINANCIAL AGREEMENT

To our valued patients:

In order to keep our fees as low as possible, we have implemented the following policies.

- If the patient does not have dental insurance, payment in full is expected on the day of service, unless other arrangements have been made.
- If the patient does have dental insurance, the responsible party will need to pay the patient portion and deductible on the day of service; the insurance will be billed as a courtesy, however, please be aware, if the insurance does not pay within 60 days from the date of service, payment in full is expected from the responsible party. We bill to hundreds of insurance companies.
- As the responsible party I understand that it is my responsibility to know and understand my benefits, and that fees quoted in this office are only estimates. I will be personally responsible for anything the insurance does not cover.
- Upon examination the doctor will prepare a treatment plan. The treatment plan is only an estimate (we cannot guarantee what the insurance will pay) of the dental care and should not be construed as a statement of actual charges.
- There will be a \$20 returned check fee assessed to your account on all returned checks.
- Financial charges, rebilling, or late fees will be added to all accounts past due.
- The responsibility party agrees to pay all attorney fees and court costs associated with collecting payment for services rendered. Collection fees of approximately 40 % are added to the account when it is turned over to the agency.

I have read and understand the above policy and agree to abide by this policy

Signature of patient or legal guardian

DATE

PATIENT'S NAME _____

CONSENT TO PROCEED:

I AUTHORIZE DR. K. JOHN LIDDIARD D.M.D. AND/OR SUCH ASSOCIATES OR ASSISTANTS AS HE MAY DESIGNATE TO PERFORM THOSE PROCEDURES AS MAY BE NECESSARY OR ADVISABLE TO MAINTAIN MY DENTAL HEALTH OR ANY MINOR OR OTHER INDIVIDUAL FOR WHICH I HAVE RESPONSIBILITY, INCLUDING BUT NOT LIMITED TO NITROUS OXIDE, GENERAL ANESTHESIA, AND ALL THOSE RELATED TO RESTORATIVE, PALLIATIVE, THERAPEUTIC, OR SURGICAL TREATMENT. I UNDERSTAND THAT THE ADMINISTRATION OF LOCAL ANESTHETIC MAY CAUSE AN OUTWARD REACTION OR SIDE EFFECTS, WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO BRUISING, HEMATOMA, CARDIAC STIMULATION, AND TEMPORARY OR RARELY, PERMANENT NUMBNESS, AND MUSCLE SORENESS. I DO VOLUNTARILY ASSUME ANY AND ALL POSSIBLE RISKS, INCLUDING THE RISKS OF SUBSTANTIAL AND SERIOUS HARM, IF ANY, WHICH MAY BE ASSOCIATED WITH GENERAL PREVENTATIVE AND OPERATIVE TREATMENT PROCEDURES IN HOPES OF OBTAINING THE POTENTIAL DESIRED RESULTS, WHICH MAY OR NOT BE ACHIEVED, FOR MY BENEFIT OF MY MINOR CHILD OR WARD. I ACKNOWLEDGE THAT THE NATURE AND PURPOSE OF THE FOREGOING PROCEDURES HAVE BEEN EXPLAINED TO ME AND I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS.

HIPAA - HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT:

WE WILL USE YOUR PROTECTED HEALTH INFORMATION WITHIN OUR OFFICE TO PROVIDE YOU WITH THE BEST DENTAL CARE POSSIBLE. THIS MAY INCLUDE ADMINISTRATIVE AND CLINICAL OFFICE PROCEDURES DESIGNED TO OPTIMIZE COORDINATION BETWEEN HYGIENIST, DENTAL ASSISTANT, DENTIST, AND OFFICE STAFF. WE MAY SHARE YOUR INFORMATION WITH PHYSICIANS, REFERRING DENTISTS, CLINICAL AND DENTAL LABORATORIES, OR PHARMACIES. WE MAY USE YOUR INFORMATION TO COLLECT PAYMENT FOR TREATMENT YOU RECEIVE IN OUR OFFICE. YOUR HEALTH INFORMATION MAY BE USED DURING PERFORMANCE EVALUATIONS OF OUR STAFF. WE MAY BE REQUIRED TO DISCLOSE TO FEDERAL OFFICIALS OR MILITARY AUTHORITIES HEALTH INFORMATION NECESSARY TO COMPLETE AN INVESTIGATION RELATED TO PUBLIC HEALTH OR NATIONAL SECURITY. WE MAY NOTIFY GOVERNMENT AUTHORITIES IF WE BELIEVE A PATIENT IS THE VICTIM OF ABUSE, NEGLECT OR DOMESTIC VIOLENCE. BECAUSE WE BELIEVE REGULAR CARE IS VERY IMPORTANT TO YOUR ORAL AND GENERAL HEALTH, IT WILL BE NECESSARY TO USE YOUR INFORMATION TO CONTACT YOU REGARDING YOUR TREATMENT, INCLUDING SCHEDULING, FOLLOW-UP CARE AND REMINDER CALLS.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN
(PARENT, LEGAL GUARDIAN OR AUTHORIZED AGENT OF PATIENT)

DATE