Patient Information

Patient Name: ______________________________ Date: ______________
Last First MI

Gender: ☐ Male ☐ Female Status: ☐ Married ☐ Single ☐ Child ☐ Other______________

Referred by:____

Social Security #: ______________ Birth Date:____/______/_____ Email: ______________________

Phone (Home): ______________ (Work): ______________ (Cell): ______________

Address:____
Street Apartment #

____
City State Zip Code

Responsible Party Information

(Person Responsible For Payment)

Name: ____

Gender: ☐ Male ☐ Female Status: ☐ Married ☐ Single ☐

Social Security #: ______________ Birth Date:_______/___________/_________

Phone (Home): ______________ (Work): ______________ (Cell): ______________

Address:____
Street Apartment #

____
City State Zip Code

Insurance Information

Primary Insurance:

Name of Insured: Last______________________

First______________________MI__________

Is insured a patient? ☐ Yes ☐ No

Relationship to insured:☐Self ☐Spouse ☐Child ☐Other

Insured's Birth Date: ____/_______/______

Employer of Insured______________________

SS /mem.#________________Group#__________

Insurance Name:______________________

Address:______________________
Stree tApartment #

____
City State Zip Code

Phone:______________________

Secondary Insurance:

Name of Insured: Last______________________

First______________________MI__________

Is insured a patient? ☐ Yes ☐ No

Relationship to insured:☐Self ☐Spouse ☐Child ☐Other

Insured's Birth Date: ____/_______/______

Employer of Insured______________________

SS /mem.#________________Group#__________

Insurance Name:______________________

Address:______________________
Stree tApartment #

____
City State Zip Code

Phone:______________________

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.**I have read the above conditions of treatment and payment and agree to their content**.Signature__________________________________Date____________________

Relationship to insured:☐Self ☐Spouse ☐Child ☐Other

201 S. Main St., Edwardsville, IL 62025 ● Bordendentalarts.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, *(Please Print Name)* ________________________________, have received a copy of this office's Notice of Privacy Practices.

____

(Signature) *(Date)*

For Office Use Only: We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

1 - Individual refused to sign

1 - Communication barriers prohibited obtaining the acknowledgement

1 - An emergency situation prevented us from obtaining acknowledgement

1 - Other (Please Specify)_________________________________

PERMISSION TO SHARE INFORMATION ACKNOWLEDGMENT

I, (Please Print Name) ________________________________, give Borden Dental Arts permission to share information concerning my dental care with :

1.____

Name *relationship to patient*

2.____

Name *relationship to patient*

ACKNOWLEDGEMENT OF MISSED APPOINTMENT POLICY

We expect our patients to arrive on time and ready for procedures and payment at this scheduled time. If you need to reschedule your appointment, we request a 24 hour notice prior to your scheduled appointment. If you are unable to do so, you may incur a $50 charge for the time and staffing we have scheduled for your services.

I, *(Please Print Name)* ________________________________, have understood and will respect the missed appointment policy for Borden Dental Arts.

____

(Signature) *(Date)*

Borden Dental Arts Medical History

Patient Name: Birth Date: Date Created:

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.

Question	Answer	
Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Do you use controlled substances?	Yes No	If yes

Women: Are you...

- ☐ Pregnant/Trying to get pregnant?
- ☐ Nursing?
- ☐ Taking oral contraceptives?

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Acrylic
- ☐ Metal
- ☐ Latex
- ☐ Sulfa Drugs
- ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Yellow Jaundice	Yes No						

Have you ever had any serious illness not listed above? Yes No If yes

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 of Patient, Parent or Guardian:

X

Date:__________