

• Have you ever had any complications following dental treatment? Yes No
If yes, please explain:

• Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain:

• Are you now under the care of a physician? Yes No
If yes, please explain:

• Are you currently taking any medication? Yes No
If yes, please list ALL medications and explain the reason for taking the medication:

• Name of Physician: _____ Phone: _____

• Do you have any health problems that need further clarification? Yes No
If yes, please explain:

On a scale of one to ten, (Ten being the highest) how would you rate your overall dental health? _____

On a scale of one to ten, (Ten being the highest) how would you rate your teeth? _____

Are you happy with the color of your teeth? _____

Is there anything you would like to change about your teeth? _____

Have you ever considered having a smile makeover? _____

(So that we may assist our patients with the finance portion of their visit, we are pleased to offer an interest free financing program through Care Credit.)

Would you like to apply for your pre approved (Care Credit) interest free financing program? _____

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient

Date

Name of Parent or Guardian (please print)

Signature of Parent or Guardian

Date

Referral Information

Whom may we thank for referring you to our practice?

- Dr. _____ Patient: _____ Insurance Website Mailer Internet Groupon
 Other _____

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. 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 full at the time services are performed.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay the value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the 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 cost including attorney fees if suit be instituted hereunder.

Insurance: Dental insurance is a contract between you and the insurance company. Despite our efforts, there is no guarantee of benefits or reimbursement. As a courtesy, we will bill your insurance company on your behalf. *If your insurance company has not made payment within 30 days, the outstanding balance becomes your responsibility.* I fully understand and agree my financial arrangements and obligations with Weninger Dentistry supersede any and all insurance contracts that either I or Weninger Dentistry may have signed. I authorize Weninger Dentistry to send any and/all dental information to my insurance company.

Collections: A service charge of (21% per annual) on the unpaid balance as well as \$5.00 per month late fee will be charged on all accounts exceeding 7 days past due. If balance is outstanding longer than 7 days, Patient agrees to pay all fees, including but not limited to: late fees, interest fees, as well as attorney and/or collections fees totaling an additional fee of 50% of outstanding debt. Report to a collection agency may also occur if balance has not been paid after 45 (forty-five) days.

No Shows/Appointment Cancellations: We respectfully request a 48-hour notice if you cannot keep your scheduled appointment. This will allow us not only to serve those patients who are on a waiting list, but will prevent your account from receiving a No Show / Cancellation fee of \$35 or up to full visit fee, depending on the length of the appointment that not kept. (No Show consists of not showing up for your scheduled appointment or calling less than 48 hours to cancel an appointment.) We do understand that medical or family emergencies do arise, therefore exceptions to this policy will be handled on a case by case bases. Please Note: Patients with **three no show appointments** will be asked to transfer their records to another dentist.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient Date: _____

Name of Parent or Guardian: (please print) Signature of Parent or Guardian Date: _____

HIPPA

I, _____ have read a copy of the Health Insurance Portability and Accountability Act (HIPAA). I understand that if I wish to have a personal copy, one will be provided to me.

Telephone, Email and/or Text Messages:

I grant my permission to you or your assignee(s), to contact me (including leaving messages on my voice mail, email, text or with any individual answering the phone) related to any of my dental records, dental treatment, account balance, account collection matters, dental appointments, or any other dental matter.

Reminder Cards:

I grant permission to send reminder postcards for scheduled and/or unscheduled appointments which will state the date, time, and/or type of appointment.

Persons requesting patient information:

I understand that Weninger Dentistry will not release any dental information such as: necessary treatment, procedure fees, appointment information (including but not limited to: date and time of appointment or reason for the appointment), to any individual who is personally requesting the above information unless I have authorized this office to do so.

Authorization to release information to individuals requesting dental records:

I, _____, authorize Weninger Dentistry to release ANY and ALL dental information to the following people. I also understand that Weninger Dentistry **will not** be held responsible for verifying identification on the individuals listed below.

Name: _____
(Please Print) (Friend or Family Member)

Name: _____
(Please Print) (Friend or Family Member)

Date: _____

Signature of patient

Date: _____

Name of Parent or Guardian: (please print)

Signature of Parent or Guardian

I understand that by signing this form, I am verifying that I have received and/or read a copy of the Health Insurance Portability and Accountability Act (HIPAA) and I have read the above office policy and agree to their content.

Patient's Signature Date: _____

Name of Parent or Guardian (please print) Signature of Parent or Guardian Date: _____