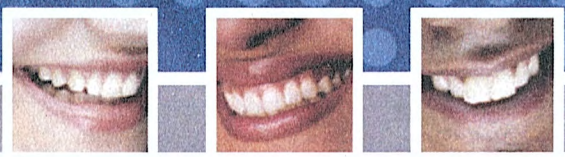
Cosmetic & Family Dentistry
114 West Columbia Street
Weatherford, TX 76086

817-594-3806

cafd11@sbcglobal.net
www.weatherforddentistry.com



Patient Information

Please take a moment to enter or update your information to help us ensure the qulaity of your care is excellent.

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Birthdate:

_____

Gender

◯ Male ◯ Female

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Email Address

_____

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Newspaper
☐ Yellow Pages ☐ Internet
☐ School ☐ Work
☐ Parker County Today Magazine ☐ Other (name below)

Name of person, office, or other source referring you to our practice:

_____

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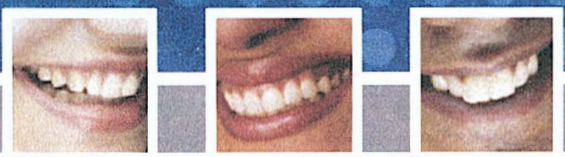

Responsible Party Information

Name of Responsible Party & Relationship to Patient:

Address:

City | State | Zip Code

Phone: Home | Work | Ext | Mobile

Best time to call:

Primary Insurance Information

Name of Insured: Last | First | MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

Insurance Company Phone:

Insured's Birth Date:

ID#:

Insured's Employer Name:

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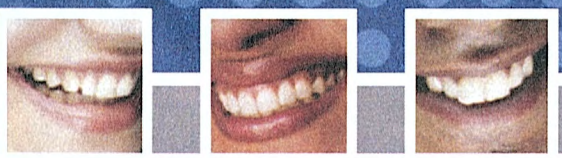

Patient Name: Last | First | MI | Preferred Name

What is your main concern today?

Are you under medical treatment now?
Have you been hospitalized for any surgical operation in the last 5 years? If so, please explain.

Are you pregnant?

◯ Yes ◯ No

Please list in the box below any medication(s) including non-prescription medicine, vitamins or supplements you are currently taking? If you have a list that we can make a copy of, please inform receptionist.

Are you allergic to or have you had any reactions to the following?

☐ No Known Drug Allergies
☐ Penicillin or any other antibiotic
☐ Aspirin
☐ Local Anesthetics (e.g. Novacaine)
☐ Sulfa Drugs
☐ Latex Rubber

OTHER ALLERGIES

Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?

◯ Yes ◯ No

Do you use tobacco?

◯ Yes ◯ No

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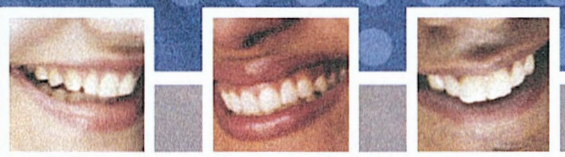

Do you have or have you had any of the following?

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Diabetes
- ☐ Cardiac Pacemaker
- ☐ Joint Replacement or Implant
- ☐ Sexually Transmitted Disease
- ☐ Heart Problems
- ☐ Stomach Problems/Ulcers/Reflux
- ☐ Asthma
- ☐ Epilepsy/Convulsions/Seizures
- ☐ AIDS/HIV Infection
- ☐ Cancer/Chemotherapy/Radiation
- ☐ Hepatitis/Jaundice
- ☐ Respiratory Problems
- ☐ Thyroid Problems
- ☐ Stroke

Do your gums bleed while brushing or flossing?

◯ Yes ◯ No

Are your teeth sensitive to hot or cold liquids/foods? Are your teeth sensitive to sweet or sour liquids/foods? If so, which one and where?

Do you feel pain in any of your teeth? If so, where?

Do you have any sores or lumps in or around your mouth? If so, where?

Do you like your smile? If no, why not?

NOTES

Response Date:

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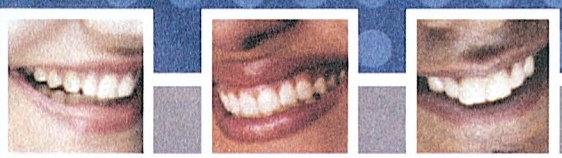

FINANCIAL POLICY/ASSIGNMENT OF BENEFITS

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from 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 and any dental services performed without previous financial arrangements must be paid for in cash at the time services are rendered.

I understand that the fee estimates for dental care can only be extended for a period of six months from the date of consultation.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. 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.

Patients who carry dental insurance understand that all dental services 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 and assist in making collections from insurance companies, and will credit any collections from insurance to the patient's account. However, this dental office cannot render services on the assumption that the resulting charges will be covered by insurance.

I grant my permission to you or your assignee, to telephone me to discuss matters related to this form.

Although we are willing to electronically file insurance forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.

We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.

Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately yor responsibility to resolve any type of dispute over payments made or not made by your insurance company.

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

Signature of guarantor of payment/responsible party:

Signature: _____ Date: _____

Response Date: _____

ASSIGNMENT OF BENEFITS AGREEMENT

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.
- We require you to pay the copayment, which is the amount not covered by your insurance company, at the time we provide service to you.
- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
- Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if you claim is denied, you will be responsible for paying the full amount at that time.
- **Our office will not enter into a dispute with your insurance company over any claim,** although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company, It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I have read and understand the above conditions. I hereby authorize my insurance company to pay my dental benefits directly to the doctor.

Signature of Patient/Responsible Party Date