DAVIS DENTISTRY

Date: _____

Patient Name: _____
Last First M (preferred name)

Gender M / F **Marital Status**: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Date of Birth: _____ **Social Security #:** _____**E-Mail Address:**_____

Address:_____
Street Apartment #

_____
City State ZIP

Phone #'s: Home _____ Work _____ Ext_____ Cell _____

INSURANCE

Primary Insurance
Insurance Co. Name _____
Address: _____
Phone #: _____
Group #: _____ID# _____
Insured's Name: _____
Insured's DOB ____/____/___ SS# _____

Secondary Insurance
Insurance Co. Name: _____
Address: _____
Phone #: _____
Group #: _____ID# _____
Insured's Name: _____
Insured's DOB ___/___/___ SS# _____

Are you currently taking Coumadin (warfarin)? [ ] Yes **[ ]** No **Are you taking Plavix or aspirin? [ ]** Yes **[ ]** No

Have you ever had bacterial endocarditis? [ ] Yes [ ] No If Yes, Approximate date(s)_____

WOMEN: Are you pregnant? [ ] Yes **[ ]** No **Nursing? [ ]** Yes **[ ]** No **Taking birth control? [ ]** Yes **[ ]** No

Check if you have now, or have had in the past, any of the following: (all must be checked. Even if they are a NO)

Yes/No	Yes/No	Yes/No	Yes/No
[ ] [ ] Abnormal bleeding	[ ] [ ] Chemotherapy	[ ] [ ] Hemophilia	[ ] [ ] Pacemaker
[ ] [ ] AIDS/HIV positive	[ ] [ ] Circulatory problems	[ ] [ ] Herpes	[ ] [ ] Psychiatric care
[ ] [ ] Anaphylaxis	[ ] [ ] Diabetes	[ ] [ ] Hepatitis A, B, or C	[ ] [ ] Radiation treatment
[ ] [ ] Anemia	[ ] [ ] Epilepsy	[ ] [ ] High blood pressure	[ ] [ ] Respiratory disease
[ ] [ ] Angina	[ ] [ ] Fainting	[ ] [ ] Jaw pain	[ ] [ ] Shortness of breath
[ ] [ ] Arthritis	[ ] [ ] Food allergies	[ ] [ ] Kidney disease	[ ] [ ] Sub Bacterial Endocarditic
[ ] [ ] Artificial heart valves	[ ] [ ] Headaches	[ ] [ ] Latex allergy	[ ] [ ] Surgical implant
[ ] [ ] Artificial joints	[ ] [ ] Head Trauma	[ ] [ ] Liver disease	[ ] [ ] Tobacco use
[ ] [ ] Asthma	[ ] [ ] Heart murmur	[ ] [ ] Material allergies	[ ] [ ] Tonsillitis
[ ] [ ] Cancer	[ ] [ ] Heart surgery/Stent	[ ] [ ] Mitral valve prolapse	[ ] [ ] Transplants

List all medications you are currently taking, if any:_____

_____

Have you ever had an adverse reaction to any of the following?

[ ] Antibiotics _____
[ ] Aspirin
[ ] Dental Anesthetics
[ ] (Lidocaine/Novocain)
[ ] Penicillin
[ ] Codeine
[ ] Pain Medications
[ ] Other _____

Consent and Policy

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize the insurance company listed in these forms to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions:

For patients with Insurance:

Benefits for dental treatment vary from plan to plan. Additionally, "Out of Network" benefits are subject to deductibles that vary with each plan. In an effort to provide clear communication with our patients, please be advised as follows;

- We are a contracted provider of Delta Dental "Preferred," Guardian Dental, and Cigna Dental. Any other PPO or Indemnity insurance will be considered "Out of Network" and will require payment in "Full" at the time of service. We will be happy to submit the claims on your behalf for reimbursement.
- The contractual agreement for your dental benefits is between you and the insurance company. **We provide billing as a courtesy**.
- For all insurance carriers that we have a contractual agreement with, we will accept the "In Network" benefits outlined on your individual Explanation of Benefits. You will still be responsible for any or all co-pays, deductibles, or co-insurance amounts due in accordance with the explanation of benefits.
- When insurance benefits have been exhausted and/or terminated, you are responsible for any charges incurred.
- In all cases, you will be responsible for non-covered services that are not covered by your dental plan.
- We are limited to the information that is given to us by your insurance company and cannot be held responsible for percentages or benefits estimated**.**
- **However, it is your responsibility to know your dental plan coverage**.

Payment Agreement:

- **Payment is due when services are rendered.** Accounts may be assessed a late charge of 1 ½% per month, not to exceed 18% annual interest. If any account is sent to collections a collection fee will be added to your account.
- Should your account be placed in collections, you will be responsible for any and all fees and court costs incurred.

I authorize the doctors of Davis Dentistry and office to release all information necessary to secure the payment of benefits. I have read and agree to be financially responsible for all services performed by Dr. Mark Davis and staff.

Printed Name _____

Signature _____ ***Date*** _____