New Patient Form

Welcome to our office! To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.

Patient Information

Patient's name ______________________________ Preferred name ______________ Birth date______________

If minor, parents names ________________________ Home phone ____________ Work phone ______________

Mailing address ______________________________ City ________________State ______ Zip ________

Email Address______________________________ Social Security Number ______________________

Employer __________________________ Occupation ____

Spouse's name _______________________ Spouse's employer __________________________ ❑ Unmarried

Whom may we thank for referring you to our office? ____

Emergency Contact Information: Name______________Relationship________________ Phone_______________

BILLING, CREDIT, AND INSURANCE INFORMATION:

Dental Insurance Coverage ❑ Self ❑ Spouse ❑ Guardian or Responsible Party ❑ Not covered by dental insurance

Responsible Party Policy Information

The Following Policy Information is for: ❑ Self ❑ Spouse ❑ Guardian or Responsible Party ____________

Name of Policy Holder__________________________ Preferred name ______________ Birth date__________

Policy Holder Social Security #______________________ Home phone ___________ Work phone ___________

Mailing address ______________________________ City ________________State ______ Zip ________

Employer __________________________ Occupation ____

Email Address ________________________

Dental Insurance Co.___________________ Group, Plan, or Policy Number______________________

Insurance Company Mailing address ____________________________ Telephone #__________________

City ____________________ State ______ Zip ______________

As a courtesy to our patients with dental benefit plans, we will submit necessary claim forms, receipts and other information to your information to your insurance company. Upon receipt of an insurance payment, any balance due will be billed to you. Any balance outstanding with our office after 45 days from the date of service becomes the responsibility of the patient, regardless if a claim is pending payment by insurance. If you have deposited an excessive co-payment, it will be refunded to you.

PATIENT AUTHORIZATION FOR RELEASE OF HEALTH RECORDS TO EXTERNAL PARTIES

I authorize the disclosure of information from my treatment records to: (If no one simply write NO ONE)

Name of Recipient ____________________________

Relationship to the Patient ________________________

I give authorization to disclose the following information:

❑ All treatment information ❑ Information specifically related to these treatment dates; Starting Date__________ End Date ________

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released. I may revoke this authorization by notifying River City Dentistry in writing.

Signature of Patient (or Patient Representative) ______________________________ Date ________________

Printed Name of Patient (or Patient Representative) ____________________________

Financial Agreement

Welcome to our office! To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment.

Payment options:
1. Cash
2. Check
3. MasterCard/AMEX/Visa/Discover
4. Care Credit
6. In-House financing if applicable

Patient with insurance: The PATIENT is responsible for the ESTIMATED non-covered portion, procedures and/or deductibles at the time of the service, OR the patient can sign a credit card authorization to bill their credit card AFTER insurance has paid for the visit. If the insurance company does not pay after 45 days, we will bill you directly for the full balance.
I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. Patient agrees and understands they are responsible for any and all collection costs associated with services rendered including but not limited to attorney's fees and court costs. Jurisdiction for collections and legal matters shall be Hamilton County, Tennessee.

Parents not accompanying their child to an appointment must make PRIOR arrangements for payment (cash, check or credit card authorization).

Parents accompanying their children are financially responsible for payment.

18% annual **interest** is charged for any unpaid balance. A $15 fee is charged for nonpayment.

There is a $30.00 processing charge for **non-sufficient funds** or returned checks.

Records can be viewed at any time. There is a nominal charge for release or copies of records.

Because instruments, chairs, and personnel are reserved exclusively for YOUR appointment, there is a **$25 - $50 CHARGE FOR CHANGED OR BROKEN APPOINTMENTS LESS THAN 48 HOURS IN ADVANCE**.

I, ____, agree to these financial terms.

Signature ____ Date_____________________

FOR OFFICE USE ONLY

Drivers License Number ____________________________ State __________ Expiration Date _________________________

Residence Status ❑ Own ❑ Rent ❑ Other Net Monthly Income _______________ Monthly Expenses ________________

HEALTH INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

PATIENT INFORMATION

Patient Name ________________________________ Date of Birth ______________________

Reason for visit ________________________________ Estimated date of last dental visit ______________________

HEALTH HISTORY & INFORMATION

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following? (Please check any that apply)

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:________________________________

Are you taking any of the following?
(Please check any that apply)

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine (Fosamax, etc.)
- ❑ Other:________________________________
____

Women:

- ❑ May be pregnant
  Expected delivery date: ____________
- ❑ Taking hormones or contraceptives
- ❑ Nursing

Name of your physician:________________________________ Phone Number________________________

Do you have any disease, condition, or problem not listed above?________________________________

____

Please list any medications currently being taken ____

____

I certify that I have read and understand the above questions and acknowledge that have been answered to the best of my knowledge. I here by give my consent to the dentist to perform an examination and diagnose my condition.

Signature of patient (or guardian/responsible party) ______________________ Date________________

Signature of Dr. ____ Date________________