Welcome!

Verde Pointe
DENTAL ASSOCIATES

Name_____Preferred Name_____Birth Date_____ ☐ Male ☐ Female

☐ Married ☐ Single ☐ Divorced ☐ Widowed Employer_____

Cell_____ ☐ Ok to text appointments? Work Phone_____

Email_____ ☐ Ok to email statements?

Preferred contact methods ☐ cell ☐ email ☐ text ☐ home ☐ work ☐ none

Referred by?_____ Home Phone_____

Address_____City/State/Zip_____

SSN_____ ☐ College Student College Name_____Expected Graduation Date_____

Emergency Contact_____Relationship_____Phone_____

Primary Dental Insurance Company_____Subscriber Name_____

Subscriber DOB_____ SSN/ID#_____

Relationship to subscriber ☐ self ☐ spouse ☐ child ☐ dependent ☐ significant other

Policy/Group#_____ Group name _____Insurance Phone_____

Insurance Address_____City/State/Zip_____

Secondary Dental Insurance Company_____ Subscriber Name_____

Subscriber DOB_____ SSN/ID#_____

Relationship to subscriber ☐ self ☐ spouse ☐ child ☐ dependent ☐ significant other

Policy/Group#_____ Group name _____Insurance Phone_____

Insurance Address_____City/State/Zip_____

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	Heart Problems	☐	☐	Kidney Disease	☐	☐	Use of Bisphosphonates
☐	☐	High Blood Pressure	☐	☐	Diabetes	☐	☐	Currently Pregnant (# of weeks _____)
☐	☐	Heart Valve Replacement	☐	☐	HIV			
☐	☐	Liver Disease	☐	☐	Hospitalized within last year	☐	☐	Allergic to Penicillin
☐	☐	Hepatitis	☐	☐	Cancer or Chemotherapy	☐	☐	Allergic to other Medications (List below)
☐	☐	Bleeding Problems	☐	☐	Joint Replacement			

List medication allergies_____

Medications currently taking_____

Please list any other medical condition we should know _____

_____Please share my existing dental treatment, needs and financial information with _____.

_____My child can seek previously authorized treatment without a guardian present.

_____I acknowledge the Notice of Privacy Practices Policy. I understand I may receive a copy upon request.

_____I understand I may refuse to sign the Privacy Practices Acknowledgment.

I hereby authorize any payment of dental benefits be made directly to VPDA. I also understand that any amount not covered by insurance is my responsibility and is due at time of treatment. I, the undersigned patient, or legally responsible party authorizes treatment to be rendered, and assume full financial responsibility. I acknowledge that all noncurrent balances and accounts over sixty days shall incur a service charge of 1.5% per month (18% annually) on unpaid balances. The cost incurred in collecting this account including court costs, agency fees and attorney fees shall be added to your balance due.

Signature of Person Responsible for Account_____Date_____