New Patients

Date_____

Name_____DOB_____SS#_____

Address_____

Own_____Rent_____How many years at present address?_____

Cell phone number_____Secondary (home)phone number_____

E mail address_____

Married_____Single_____Divorced_____Widowed_____

Employer_____Phone number_____

How many years have you worked at your present employer?_____

Spouse's name (or significant other)_____DOB_____

Do you have dental insurance? Yes_____No_____

Policy holder name_____SS#_____DOB_____

Employer of policy holder_____

Insurance company of policy holder_____

In effort to reward our patients for referrals, who can we thank for telling you about our practice?_____

Did you hear about us on: TV_____Radio_____Drive by_____Phonebook_____Internet_____

Referring Doctor_____Other_____

CONSENT FOR TREATMENT

Diagnosis & Treatment

I hereby authorize the Doctor and Staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's oral health. All x-rays, study models, photographs, and other diagnostic aids are the property of the dental practice and I release them for the Doctor's use for educational, study club sharing, commercial, and other uses.

Upon diagnosis, I authorize Doctor and Staff to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care. I agree to the use of anesthetics, sedatives and other medications. I fully understand that using anesthetic agents embody certain risks (i.e.,paresthesia). I understand that I can ask for a complete recital of any possible complications.

Financial

I agree to be responsible for payment of all services rendered on my behalf or my dependents, missed appointment fees, and late cancellation fees. I understand that payment is due at the time of service unless other arrangement have been made. Payment in full when scheduling the appointment with check or cash qualifies you for a 5 % bookkeeping courtesy. This office accepts VISA, MASTERCARD, DISCOVER, & AMERICAN EXPRESS. In the event payments are not received by agreed upon dates, I understand that late charges (1-1/2/18%) and/or billing charges may be added to my account. Additional fees may result from declined credit and/or debit cards and insufficient funds from my checking account. I authorize this office to obtain a credit report on myself and/or the financially responsible person.

I agree to pay all reasonable collection, attorneys and court fees, together with all other expenses involved in collecting the charges or enforcing the dental practice's rights under this agreement. I understand that the terms and conditions contained in this Consent for Treatment are applicable to all persons financially responsible for the health care provided, including, but not limited to: Children, Dependents and Spouses.

Insurance Information

I clearly understand and agree that I am personally responsible for payment of the entire cost of treatment. I also agree that the dental practice has no control whether my insurance company will or will not pay. I am fully aware that my insurance company may only reimburse based upon reduced fee schedules and may require me to pay a percentage and or deductible. My insurance company may have pre-existing condition clauses, maximum pay per year clauses, and other clauses, which limit the amount they will reimburse for treatment rendered.

Signed_____Date_____

ALLERGIES

I understand that certain prescriptions and dental materials have potential to cause an allergic reaction. I will hold Auburn Family Dentistry and Dr. Painter harmless should an unknown allergy occur and I will make them aware of any allergies I have.

DRUGS & THE PILL

If you are taking the birth control pill, please be aware that oral contraceptives may be rendered less effective or non-effective by drug interactions with other medicines including antibiotics and pain medicines. Examples of drug interactions are: Ampicillin, Neomycin, Penicillin V, Tetracycline, and Barbiturates. We want our patients to be aware that treating dental infections with antibiotics and pain medicines can inactivate the effects of the pill. If you have any concerns please consult with your physician prior to taking any medications.

DRUG INTERACTIONS

I understand any drug(s) I take can interact with drug (s) administered by the Doctor. These interactions can have harmful effects to my health and can be fatal. These drugs include: prescription drugs (Fentanyl Patch), illegal narcotics (cocaine, meth-amphetamine), over-the-counter drugs, and holistic herbs and drugs. I will fully inform the Doctor of ALL drugs used and dosages.

Proper Appointment Notification

Doctor and his staff reserve chair time for treatment. I agree to give 48 hours notice of cancellation for scheduled appointments and will pay a charge if required notice is not given. Charges vary for missed appointments depending upon the procedure booked and time reserved for procedure.

Signed_____Date_____

DENTAL INSURANCE FACTS

As a courtesy to me, the dental practice will prepare any necessary reports and forms to assist in collecting my dental reimbursement from my insurance company, however I understand and agree that…

a) My insurance is a contract between my insurance company and me. The dental practice has no control whether my insurance company will or won't pay. All services rendered to me and my dependents are charged directly to me.

b) My insurance may not reimburse a penny for treatment or selected procedures to lower their payment and increase my portion of the dental bill.

c) My insurance may only reimburse based upon a below market rate/reduced fee schedule (UCR) which may be below the dental practice, to lower their payment and increase my portion of the dental bill.

d) My insurance may require me to pay a percentage and/or deductible to lower their payment and increase my portion of the dental bill.

e) My insurance may have pre-existing condition clauses, maximum pay per procedure clauses, maximum pay per year clauses, and other clauses which limit the amount they will reimburse for the treatment rendered to lower their payment and increase my portion of the dental bill.

f) My insurance company will use language, which is disparaging to the dental practice in their estimate of benefit forms. I can only be given a rough estimate of my insurance coverage. Insurance companies find creative ways to lower their payment and increase my portion of the dental bill especially by trying to imply that unnecessary work was done or that it was done at too high of a fee.

g) If my insurance company does not reimburse or reimburses at a lower rate than estimated within 60 days of service, I will be billed and pay for service rendered.

h) The dental practice offers a 5% courtesy discount for payment in full at initiation of treatment with cash or check, and I can have my insurance benefit sent directly to myself.

i) ***I am personally responsible for payment of the entire cost of treatment***

Signature_____Date _____