



PATIENT INFORMATION — ADULT

Name _____ Birthdate _____ Age _____

Social Security # _____ E-mail Address _____

Male Female Minor Single Married Separated Divorced Widowed

Address _____ City _____ Zip _____

Employer _____ Occupation _____

Home Phone _____ Work Phone _____ Cell Phone _____

Where do you prefer to receive calls? Home Work Cell

Who may we contact incase of emergency?

Name _____ Relationship _____ Work# _____ Home phone _____

Referred by: Yellow page Insurance Fair Home Town Value Direct Mail
 Newspaper Internet Spanish phone book Friend _____

Primary Insurance

Insure's Name _____ Relationship _____

Birthdate _____ Social Security # _____

Employer _____ Work# _____ Occupation _____

Insurance Company _____ Group # _____ Employee # _____

Additional Insurance

Insure's Name _____ Relationship _____

Birthdate _____ Social Security # _____

Employer _____ Work# _____ Occupation _____

Insurance Company _____ Group # _____ Employee # _____

Financial Arrangements:

For your convenience we offer the following methods of payment. Payment in full is expected at each appointment.

Preference of Payment: Cash Personal Check Credit Card: VISA MasterCard American Express Discover Care Credit

Financial Agreement:

- 1. Payment is expected at the time of treatment.
2. Insured patients are expected to pay their deductible and percent co-payment at the time of treatment.
3. In the event of default in the payments, a service charge of 13/4% per month (21% annual rate) on the unpaid balance will be assessed. I / We agree to pay all attorney's, court costs, filing fee's, and all collections costs. Up to 50% of the amount owing may be assessed by any collection agency retained to pursue the matter. Minimum monthly finance charge is \$3.00. A \$15.00 charge will be assessed on any returned checks.

Insurance Release:

I understand and agree that dental insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. Dr. Young's office only estimates the insurance co-payment. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also assume responsibility to inform Dr. Young's office of benefits that may have been paid to another office during the plan year so that yearly maximums can be determined. I hereby authorize release of any information, including diagnosis and records of any treatments or examinations rendered, charges billed, payments made, and interest charges assessed, etc. to my insurance company or companies or any other agency necessary for the collection of this account. I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile, or paper form to my insurance carrier or any related entities that require such information to be submitted. This release is solely for the purpose of facilitating the billing and reimbursement directly to the doctor of insurance benefits under which I am entitled. This authorization is considered to be effective for present and all future insurance claims.

I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

Signature _____ Date _____

DENTAL / MEDICAL HISTORY (CONFIDENTIAL)

| health information: | Please indicate | YES or NO | | YES or NO |
|--|------------------------|------------------|--|------------------|
| Is child in good health? | _____ | _____ | Tuberculosis? | _____ |
| Does child presently have pain? | _____ | _____ | Radiation treatment? | _____ |
| Is child under a physician's care now? | _____ | _____ | Abnormal blood pressure? | _____ |
| Has child ever had: | | | Hepatitis? | _____ |
| Abnormal heart condition? | _____ | _____ | Blood transfusion? (give date) | _____ |
| Artificial valve? | _____ | _____ | Venereal disease? | _____ |
| Rheumatic fever? | _____ | _____ | AIDS or HIV positive? | _____ |
| Diabetes? | _____ | _____ | Allergies? (specify) | _____ |
| Abnormal bleeding? | _____ | _____ | Jaw joint pain, clicking, popping | _____ |
| Artificial joint? | _____ | _____ | Females, are you pregnant? | _____ |
| Unusual reaction to any drug or local anesthetic? | _____ | _____ | Is there any other information about child's health that should be known? | _____ |
| Oral Contraceptives <small>(Antibiotics render oral contraceptives ineffective)</small> | _____ | _____ | | |

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

Signature _____ Date _____

INFORMED CONSENT:

I authorize Dr. Young and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or for the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

AUTHORIZATION AND RELEASE

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents behalf.

Signature _____ Date _____
parent or legal guardian

Notice of privacy practices can be obtained from the receptionist.
Thank you for filling out this form completely.
The information you have provided will help us serve your dental healthcare needs more effectively and efficiently.
If you have any questions at anytime, please ask— we are always happy to help.