Angel Way Dental

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: _____
Street Email Address

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies _____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ _____
☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Insurance Website ☐ Yellow Pages ☐ Allen Image ☐ Advertisement ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Angel Way Dentistry
Family & Cosmetic Dentistry

Consent to Disclose
Private Healthcare Information
For treatment , Payment ,and/or Healthcare Operations

I_____, hereby authorize and consent Angel Way Dentistry P.A. To release any and all medical ,dental ,and /or psychological reports or records , including ,but not limited to, medical /dental notes physician narratives, office notes ,operative notes, discharge summaries, Doctor's/Dentist's orders, Nurse's notes lab reports, test results ,physical therapy progress notes, patient progress reports, diagnosis, post-operative reports, post-diagnosis, pathology reports, x-rays, MRI'S, any records reflecting treatment for substance abuse, mental illness, AIDS, HIV virus ,alcohol abuse, including any x-rays, diagnostic studies, laboratory slides, clinical abstract, histories, charts, and other information contained therein, any documents and opinions relevant to past, present, or future physical and mental condition, treatment, care or hospitalization, and any other personal health information regarding my medical/dental care as necessary to carry out treatment, obtain payment, and/or conduct other healthcare operations.

The release of the matters listed above is being authorized for purposes of obtaining medical/dental treatment, payment for such services and other healthcare operations.

A copy of this authorization is agreed by the undersigned to have the same effect and force as an original.

Any person, firm, or entity that releases matters pursuant to this authorization is hereby absolved from any liability that might otherwise result from the release of those matters.

I further understand that I have the right to review Angel Way Dentistry P.A.'s privacy notice and to request restrictions. I further understand that I may revoke this consent in the future if I should so desire.

Signed this _____Day of _____,20_____.

Signature

_____

Angel Way Dentistry

Family &Cosmetic Dentistry

Financial Policy

Please remember your insurance policy is a contract between you and the insurance company. You are responsible for all charges incurred on your account. It is your responsibility to make sure all your information on your account is current and accurate. It is your responsibility to know what your contract covers or pays regarding your co-pay/deductable/co-insurance amount and any restrictions your insurance company might have.

For your convenience we accept personal checks; with valid identification card, cash, and credit/debit cards (Visa, MasterCard, and Discover). Should your payment result in NSF we will apply an additional $25.00 to the balance for the fees associated by the bank. At any time your balance is referred to collections for non-payment we will apply an additional 30%-40% to your current balance. This is what the collection company will charge.

Signature of Insured, Patient, or Authorized Representative

Date

Angel Way Dentistry

Family & Cosmetic Dentistry

There will be a $75.00 charge on all **No Show/No Call Appointments.** It is the policy that you must contact our office at least **48 HOURS** prior to your scheduled appointment if you are unable to make the appointment. We do understand that under certain circumstances you may be unable to contact us within 48 hours and we are willing to work with you if this occurs.

By signing below, I have read the above statement and understand this policy.

Patient/Guarantor Date