ForumDental.com

DATE_____

PATIENT INFORMATION

First name_____ Male_____ Female_____ Date of Birth_____ Marital Status_____
Preferred Name_____ SSN_____ Email_____
Last Name_____ Address_____
Home #_____ City_____ State_____ Zip_____
Cell#_____ Employer_____

SPOUSE OR GUARDIAN INFORMATION

First name_____ Male_____ Female_____ Date of Birth_____ Marital Status_____
Preferred Name_____ SSN_____ Email_____
Last Name_____ Address_____
Home #_____ City_____ State_____ Zip_____
Cell#_____ Employer_____

DENTAL INSURANCE

Primary Insurance

Subscriber Name_____ DOB_____ Group #_____ Employer_____
Insurance Company_____ SSN or Alternate ID_____

Secondary Insurance

Subscriber Name_____ DOB_____ Group #_____ Employer_____
Insurance Company_____ SSN or Alternate ID_____

PLEASE PROVIDE STAFF WITH COPIES OF INSURANCE CARDS IF THEY ARE PROVIDED TO YOU

MEDICAL AND DENTAL HISTORY OF PATIENT

Prior Dentist_____ Last Exam_____ Last Dental X-rays_____
Dental History_____
Physicians Name_____ Phone Number_____ Last Visit_____

CIRCLE ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD OR CURRENTLY HAVE

Anemia	Artificial Joints	Arthritis	Asthma	Aids/HIV	Acid Reflux
Back Problems	Cancer	Chemo	Diabetes I or II (circle)	Dizziness	Fainting
Headaches	Heart Attack	Herpes	High Blood Pressure	Low Blood Pressure	
Kidney Disease	Liver Disease	Osteoporosis	Pacemaker	Radiation	Respiratory Problems
Tumor	Thyroid Problems	Any Other_____			
Latex Allergy	Penicillin Allergy	Sulfa Allergy	Metal Allergy	Codeine Allergy	

Any Other Allergies_____

Taking Blood Thinners? Name _____ Nursing or Pregnant?_____ Due Date_____

Medications You Are Taking _____

*IN CASE OF AN EMERGENCY WHOM MAY WE CONTACT OUTSIDE OF 911?

Name_____ Relation_____ Phone_____

Note both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and the information given on this form is accurate. I understand the importance of a truthful health history and my dentist and staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any forum dental staff member responsible for any action they take or do not take because of errors and omissions that I may have made in the completion of this form.

Signature of Patient/Guardian_____ Printed Name_____

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DATE_____

Assignment and Release I certify that I, and/or my dependent(s), have insurance coverage and assign directly to forum dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions. Forum dental may use my health care information and may disclose such information to the above-named insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.
Signature of patient/guardian_____ Printed name_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, _____, have received a copy of this office's notice of privacy practices.
Signature of Patient/Guardian_____ Printed Name_____

For office use only – we attempted to obtain written acknowledgement of receipt of our notice of privacy practices, but acknowledgment could not be obtained because: ____ individual refused to sign ____ communications barriers prohibited obtaining ____ an emergency situation prevented us from obtaining ___ other (specify)

FINANCIAL AND INSURANCE ASSISTANCE PAYMENT POLICY

Insurance we will assist you with acquiring your insurance benefits by filing your claim for each date of service treatment is performed. You must supply us with all necessary forms, information and policy numbers. We do this as a courtesy for you. Legal cases: we do not treat patients on a contingency basis; payment is due when treatment is rendered, even where legal cases are pending settlement. Financial charges: any unpaid balance that is 90 days overdue will assume a 1.8% finance charge per month until the balance is paid. A collections agency will be contracted if we are unable to collect the balance which does reflect on your credit report.

Acknowledgement

Payment responsibility I, _____, agree to assume full financial responsibility for my bills with Forum Dental, its doctors and/or entities in the event my insurance does not pay. I assume responsibility for understanding the terms of my insurance policy. I understand I am responsible for obtaining authorization referrals from my primary care physician or insurance company if such is required by my insurance policy.

Form of payment (circle whichever apply) Cash Check Credit Card Care Credit

Signature of Patient/Guardian_____ Printed Name_____

Thank you for choosing us to care for your dental needs! We appreciate you and your family!
Please help us by letting us know how you heard about us?

Facebook Internet Google Radio Newspaper Friend/Family Name_____