PATIENT INFORMATION

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

Social Security #: _____ Birth Date: _____

E-Mail: _____ Gender: _____ Family Status: _____

Phone (Home): _____ (Work): _____ Ext. _____ (Cell): _____

Address: _____
Street Apt.#

_____
City State Zip

Name of Person or Office referring you to our practice: _____

Date of Last Dental Visit: _____ Reason for Today's Visit: _____

HEALTH INFORMATION

Please check those that apply:

- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Epinephrine Sensitivity
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Kidney Disease
- ☐ Liver Disease, Hepatitis, Jaundice, Cirrhosis
- ☐ Lung Ailments, Respiratory Problems
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pregnant/date due _____
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tobacco Use
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

OTHER:

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

ALLERGIES TO DRUGS? Please List: _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you ever had any injury to your face or jaws? ☐ Yes ☐ No
- Have you been admitted to a hospital or needed emergency care during the past five years? ☐ Yes ☐ No
  If yes, please explain: _____
- When was the last time you were examined by a physician? _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- **WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?** _____

_____

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.

Health History Change	**Signature of patient, parent or guardian**	**Date**

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: _____

_____

Secondary

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.

I understand that the fee estimate listed for this dental care can only be extended for a period of 1 year 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.

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

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

FINANCIAL POLICY

Due to the large number of insurance plans, we **CANNOT** be responsible for exactly quoting your particular coverage. We will submit your claims and try to obtain the maximum benefit allowed. However, it is important that you be aware of your own policy benefits, maximum and limitations.

Our office accepts cash, check, Visa, and Mastercard. We also offer dental financing that can be obtained thru Care Credit, a dental financing company

Thank you for your understanding in this matter.

Signature Date

_____ _____

I, (print)_____, give Mark Vanderkaay DDS, Nathan Martzke DDS and or dental hygienist, my consent for treatment for myself and or my dependants. I understand by signing this form, information may be used and disclosed for TPO (treatment, payment and heathcare operation) only. Also, if I consent and undertake this treatment, I accept responsibility for payment

Signed _____ Date _____

I authorize the above named dentist to submit all insurance forms for myself and/or family members to my insurance company, utilizing the signature on file below. I hereby authorize payment directly to the dentist unless otherwise payable to me.

Signed _____ Date _____

Paitents have the right to : Review Practice Privacy Notice, requests restrictions and revoke consent.

No Show Policy

Due to the high demand for appointments in our office, we have enacted a **NO SHOW POLICY**.

1. There will be NO charge for the first cancellation or no show within 24 hours of the appointment.
2. There may be a $50.00 charge for the 2nd and no show within 24 hours of appointment.

Our office staff attempts to contact all patients 2 days prior to their appointment and this can be done by phone, text or email. Your choice.

Unfortunately, missed or failed appointments contribute to inefficient scheduling, lost time and increased fees. Please understand this policy is meant to keep our practice running efficiently and keep your treatment as affordable as possible at a high level of quality.

If you have any questions, please feel free to ask.

Sincerely yours,

Dr Mark Vanderkaay and Dr Nathan Martzke and staff

Please initial here _____