DALLAS STREET DENTAL

Patient Information *(CONFIDENTIAL)*

☐ Male ☐ Female

Today's Date _____

Home Phone _____

Cell: _____

Email _____

Name _____ Birthdate _____ Soc. Sec # _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

If Patient is a Student, Name of School / College _____ City _____ State _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

How do you prefer to be contacted? ☐ Text ☐ Email ☐ Cell ☐ Home ☐ Work Please List _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ Cell Phone _____

Employer _____ Work Phone _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No Name of Bank _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No

Dental History

Reason for Today's Visit? _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a check to indicate if you have any of the following:

Bad Breath ☐

Bleeding Gums ☐

Blisters on lips or mouth ☐

Burning sensation on tongue ☐

Chew on one side of mouth ☐

Cigarette pipe or cigar smoking ☐

Clicking or popping jaw ☐

Fingernail biting ☐

Food collection between the teeth ☐

Foreign objects ☐

Grinding teeth ☐

Gums swollen or tender ☐

Jaw pain or tiredness ☐

Lip or cheek biting ☐

Loose teeth or broken filings ☐

Mouth breathing ☐

Mouth pain, bruising ☐

Orthodontic treatment ☐

Pain around ear ☐

Periodontal treatment ☐

Sensitivity to cold ☐

Sensitivity to heat ☐

Sensitivity to sweets ☐

Sensitivity when biting ☐

Sores or growths in your mouth ☐

How often do you floss? _____

How often do you brush? _____

- OVER -

Health History

Physician_____ Office Phone_____ Date of Last Exam_____

✓ CHECK BOXES IF YOU HAVE ANY OF THE FOLLOWING

- ☐ AIDS or HIV Infection
- ☐ Anemia
- ☐ Angina
- ☐ Artificial Heart Valves
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Cancer
- ☐ Cardiac Pacemaker
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy / Convulsions
- ☐ Fainting / Seizures
- ☐ Glaucoma
- ☐ Hay Fever / Allergies
- ☐ Heart Attack
  Date of Attack_____
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Trouble
- ☐ Hepatitis
  What Type_____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Joint Replacement or Implant
  Date of Placement_____
- ☐ Kidney Diseases
- ☐ Liver Disease
- ☐ Leukemia
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Psychiatric Care
- ☐ Radiation Therapy
- ☐ Recent Weight Loss
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sexually Transmitted Disease
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Stomach Troubles / Ulcers
- ☐ Stroke
- ☐ Swollen Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problem
- ☐ Tonsillitis
- ☐ Tumor or growth on head or neck
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease
- Other_____

☐ Are you under medical treatment now? ☐ Have you ever been hospitalized for any surgical operation or serious illness?

☐ Do you use tobacco? What kind?_____

☐ Do you use alcohol? ☐ Do you use cocaine? ☐ Do you use other drugs?

Women:

Are you pregnant? ☐ Due Date_____ Are you nursing? ☐ Taking birth control pills? ☐

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name_____

Phone_____

Do you take asprin daily? ☐ YES ☐ NO

Allergies

- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. 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 behalf of my dependents.

X_____

Signauture of patient or parent if minor

Dallas Street Dental Financial Agreement and Scheduling Policy

We, the staff of Dallas Street Dental, thank you for choosing us as your dental provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities please feel free to contact Stephanie at 479-452-6600.

We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff.

We make payment as convenient as possible by accepting cash, money order, MasterCard, Visa, American Express, Discover, Care Credit, Local Trade Partners checks, and checks. A $35.00 service fee will be charged for all returned checks. Additionally, you may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

Interest

Interest will incur if a balance remains unpaid after 60 days.

Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect co-payments, co-insurance, and deductibles, as outlined by your insurance carrier.

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing

of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier we will not negotiate reduced fees with your carrier.

Miscellaneous Forms, Additional Information and Authorizations

We will provide all necessary information to have your benefits released. However, if it becomes necessary to submit redundant or unnecessary information for the completion of claim forms for school, sports, or extracurricular activities there will be an administrative fee, not to exceed **$35.00**, for the additional information.

Missed Appointments

We require notice of cancellations **48 hours** in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance: a missed appointment fee will apply. **These fees are typically $50 but not to exceed one-half of the cost of your scheduled appointment.** Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

Dental Records Fees

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines, and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for record and our fees are a reasonable cost-based fee for copies include the copying, supplies, labor, and postage of the files, and or summaries.

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

Timeliness of Appointments

We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule you if necessary. In return, we do expect the same fairness by each patient arriving on time for their scheduled appointment. Tardiness may result in a longer wait or the rescheduling of an appointment to be respectful of other scheduled patients.

Smoke Free Environment

Out of mutual respect for our staff and our patients, smoking is prohibited on the property.

I have read and understand the about financial policy. I agree to assign benefits to Dallas Street Dental whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

Signature of responsible party: _____ Date: _____