



CASTLEBURY DENTAL

Patient Information

Patient Name: _____ Date: _____
Last First MI
Male Female Married Single Child Other
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ (Cell): _____ E-mail: _____
Address: _____
Street Apartment #
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:

- Checkboxes for various health conditions: AIDS/HIV, Angina/Chest pain, Anemia, Arthritis, Artificial Joints, Asthma, Blood Disease, Cancer, Diabetes, Dizziness, Epilepsy, Excessive Bleeding, Fainting, Fosamax, Osteoporosis, Glaucoma, Growths/Tumor, Hay Fever, Head Injuries, Heart Disease, Heart Murmur, Hepatitis, High Blood Pressure, Jaundice, Kidney Disease, Liver Disease, Mental Disorders, Mitral Valve Prolapse, Nervous Disorders, Pacemaker, Pregnancy (current), Prosthetic heart valve or valve replacement, Radiation Treatment, Respiratory Problems, Rheumatic Fever, Rheumatism, Sinus Problems, Smoking, Stomach Problems, Stroke, Transplant, Tuberculosis/Emphysema, Thyroid Disease, Ulcers, Venereal Disease, Latex 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 five 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: _____
• Are you taking any medications, herbal supplements, or vitamins? 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.

Signature of patient, parent or guardian _____ Date: _____

How Did You Hear About Castlebury Dental

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
Another Patient, Friend Another Patient, Family Referring Dentist Google Social Media
Groupon Drive By Direct Mail Other
Name of person or office referring you to our practice: _____

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 _____

Insurance Information, If you do not have Dental insurance Skip to next box (Consent)

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.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 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 received a copy of Notice of Privacy Policy and Practices for Dental. _____ (initials)

When you have a schedule conflict, please notify us within 24 hours so we can change your appointment to a more convenient time.

Our policy holds to a 24 hour notice or there is a \$50 cancellation fee _____ (initials)

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

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

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