

Barrington ProDental Care, P.C.

To our patients.....

Welcome

We would like to welcome you to our office and thank you for selecting us to help you with your dental health needs.

Our Philosophy

It is only through mutual understanding and communication that the most effective and long lasting treatment can be administered. We are here to serve you in a comfortable and professional atmosphere.

Appointments

It is very important that the patient understands that appointment time is set especially for you. Appointments should be made when they can be definitely kept. A fee of \$25 per half hour of scheduled time is charged for patients who miss or cancel their appointment without a 24-hour notice.

Insurance

Your insurance contract is between you and your insurance company. The type of benefits in your contract depends on what your employer has negotiated with the company and the amount of money you wish to pay in premiums. Dental insurance is not designed to pay all of the cost of treatment, but rather to be a partial aid. For your convenience we will file your claim for you as a courtesy and we ask that you assign your insurance benefits to us.

Payment

Payments, deductibles and any co-pay are due at the time that the service is rendered unless payment arrangements are made beforehand. If there is balance on your account after 60 days it becomes your responsibility to pay it in full. If after 90 days the full balance is not paid, your account will be turned over to our collection agency or attorney. All fees incurred in the process of collecting your account become your responsibility to pay. Our office charges \$30 for returned checks. For large, more comprehensive treatment plans of \$1000 or more, a 30% deposit is required to secure your initial treatment appointment.

Payment options:

- cash, check, credit card

We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to completion of care for treatment plans of \$1500 or more.

- **no interest** payment plans from City Bank or CareCredit
 - o Allow you to pay over time with **no interest**
 - o Convenient, low monthly payment plans also available
 - o No annual fees or pre-payment penalties

Records

In order for us to make a correct diagnosis we will make very thorough records and take diagnostic x-rays, these records are property of our office. If you need a copy of your records we will gladly provide you with it. Additional charges of \$25 apply to duplicating of x-rays.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature _____ Date _____

Patient Name (Please Print) _____

PATIENT INFORMATION

DATE _____

NAME _____ MARRIED SINGLE MINOR MALE FEMALE
LAST FIRST M

SOCIAL SECURITY # _____

ADDRESS _____
STREET APT.# CITY STATE ZIPBIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME WORK CELL E-MAIL

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: PATIENT GUARDIAN SPOUSE FATHER MOTHER**INSURANCE INFORMATION**MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS - COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED**PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY**LAST FIRST M
STREET CITY STATE ZIP
HOME WORK CELL E-MAIL
BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT
EMPLOYER DENTAL INS. CO
SS# SUBSCRIBER # GROUP #**SECONDARY INSURED**LAST FIRST M
STREET CITY STATE ZIP
HOME WORK CELL E-MAIL
BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT
EMPLOYER DENTAL INS. CO
SS# SUBSCRIBER # GROUP #**PERSON TO CONTACT IN CASE OF EMERGENCY**

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

X _____
Patient or Responsible Party

Date _____ State Driver's License # _____

Has any member of your family ever been treated in our office?

 Yes NoWhom may we thank for referring you to our office?
_____**METHOD OF PAYMENT**

Responsible party currently has an account with this office

 Yes No Payment in full at each appointment (cash or personal check) Payment in full at each appointment (VISA MC OTHER)

Card # _____ Exp. Date _____

 I wish to discuss the Dental Office's Financial Policy**SERVICE CHARGE**

If I do not pay the entire new balance within _____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of _____% per month (or a minimum charge of \$_____ for a balance under \$_____) which is an annual percentage rate of _____% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

PATIENT NAME _____ DATE _____

Primary reason for this dental appointment: Examination Emergency Consultation

Dental History

Please Circle

Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations on a routine basis? Last visit _____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? Discuss _____ Yes No
Do your gums ever bleed? Discuss _____ Yes No
Do you like your smile? Why? _____ Yes No
Does food catch between your teeth? Any loose teeth? _____ Yes No
Do you want to keep your remaining teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
Have your past experiences in a dental office always been positive? _____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Yes No
Name of previous dentist (optional): _____
Date of last full mouth x-rays (16 small films or panoramic): _____

Medical History

Are you under a physician's care now? Why? _____ Who? _____ Phone _____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What? _____ Yes No
Are you on a special diet? Discuss _____ Yes No
Are you allergic to any medications or substances? Please check box below _____ Yes No
 Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Milk Other _____
Women (Please check): Pregnant/trying to get pregnant Nursing Taking oral contraceptives Discuss _____ Yes No

Do you now have or have you ever had any of the following? Do you take any of these medicines? Please check appropriate boxes.
*If yes to any of the starred conditions, please call prior to your appointment... premedication or changes in medication may be required.

Table with 4 columns of conditions and Yes/No checkboxes. Conditions include Heart Disease/Surgery*, Excessive Bleeding, Chemotherapy, Night Sweats, Cold Sores, etc.

Have you ever had any other serious illness not checked above? Discuss _____ Yes No
Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____ BP _____ Pulse _____

History Review and Significant Findings _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

Table with columns: DATE, EXCEPTIONS, PATIENT'S SIGNATURE, BP, PULSE, REVIEWED BY. Includes rows for updates with 'None' and checkboxes.