Birkdale Dental

General & Cosmetic Dentistry

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(704) 997-8280

PATIENT INFORMATION & CONSENT FORM

PATIENT INFORMATION

Date:_____

Patient Name:_____ Preferred Name:_____
LAST FIRST MI

[ ] Male [ ] Female [ ] Married [ ] Single [ ] Child [ ] Other _____

Social Security #:_____ Birth Date:_____

Phone (Home):_____ (Cell):_____ (Work):_____Ext._____
Text message- YES or NO

E-Mail Address:_____

Address:_____
STREET APARTMENT #

_____
CITY STATE ZIP CODE

RESPONSIBLE PARTY

Name & Relation to Patient: _____

Social Security #:_____ Birth Date:_____

Phone (Home):_____ (Cell):_____ (Work):_____Ext._____
Text message- YES or NO

E-Mail Address:_____

Address:_____
STREET APARTMENT #

_____
CITY STATE ZIP CODE

PATIENT INFORMATION & CONSENT FORM (CONTINUED)

INSURANCE INFORMATION

Primary Policy Holder: _____
LAST FIRST MI

Birth Date: _____ SS#:_____

Insurance Plan Name:_____ Insurance Phone Number:_____

ID #: _____ Group #: _____

Employer Name: _____ Phone Number:_____

Patient's relationship to insured: [ ] Self [ ] Spouse [ ] Child [ ] Other:_____

REFERRAL INFORMATION

Whom may we thank for referring you/ How did you hear about our office?

[ ] Sign on Sidewalk [ ] Postcard in Mail [ ] Web _____
[ ] Friend [ ] Other: _____

Name of person or office referring you to our practice:
_____

We know we have a lot of paperwork, thank you for being patient with all the information we need! Please turn the page (try not to strangle the front desk girl) and keep going!

We're SO glad you're here!

PATIENT INFORMATION & CONSENT FORM (CONTINUED)

HEALTH INFORMATION

Date: _____

Patient Name: _____

Reason for today's visit: _____ Date of Last Dental Cleaning: _____

What would you like to improve about your smile?_____

Are you under a physician's care now? _____
Have you ever been hospitalized or had a major operation? _____
Have you ever had a serious head or neck injury? _____
Are you taking any medications, pills, or drugs? _____
Do you take, or have you taken Phen-Fen or Redux? _____
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? _____
Are you on a special diet? _____
Do you use tobacco? _____

Women: Are you…
[ ] Pregnant/Trying to get pregnant? [ ] Nursing [ ] Taking Oral Contraceptives?

Are you allergic to any of the following?

[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Acrylic

[ ] Metal [ ] Latex [ ] Sulfa Drugs [ ] Local Anesthetics

Do you use controlled substances? _____
Other: _____

Do you have, or have you had, any of the following?:

AIDS/HIV [ ]	Blood Transfusion [ ]
Alzheimer's Disease [ ]	Breathing Problems [ ]
Anaphylaxis [ ]	Bruise Easily [ ]
Anemia [ ]	Cancer [ ]
Angina [ ]	Chemotherapy [ ]
Arthritis/Gout [ ]	Chest Pains [ ]
Artificial Heart Valve [ ]	Cold Sores/Fever Blisters [ ]
Artificial Joint [ ]	Congenital Heart Disorder [ ]
Asthma [ ]	Convulsions [ ]
Blood Disease [ ]	Yellow Jaundice [ ]

PATIENT INFORMATION & CONSENT FORM (CONTINUED)

Cortisone Medicine [ ]	Lung Disease [ ]
Diabetes [ ]	Mitral Valve Prolapse [ ]
Drug Addiction [ ]	Osteoporosis [ ]
Easily Winded [ ]	Pain in Jaw Joints [ ]
Emphysema [ ]	Parathyroid Disease [ ]
Epilepsy or Seizures [ ]	Psychiatric Care [ ]
Excessive Bleeding [ ]	Radiation Treatments [ ]
Excessive Thirst [ ]	Recent Weight Loss [ ]
Fainting Spells/Dizziness [ ]	Renal Dialysis [ ]
Frequent Cough [ ]	Rheumatic Fever [ ]
Frequent Diarrhea [ ]	Rheumatism [ ]
Frequent Headaches [ ]	Scarlet Fever [ ]
Genital Herpes [ ]	Shingles [ ]
Glaucoma [ ]	Sickle Cell Disease [ ]
Hay Fever [ ]	Sinus Trouble [ ]
Heart Attack/Failure [ ]	Spina Bifida [ ]
Heart Murmur [ ]	Stomach/Intestinal Disease [ ]
Heart Pacemaker [ ]	Stroke [ ]
Heart Trouble/Disease [ ]	Swelling of Limbs [ ]
Hemophilia [ ]	Thyroid Disease [ ]
Hepatitis A [ ]	Tonsillitis [ ]
Hepatitis B or C [ ]	Tuberculosis [ ]
Herpes [ ]	Tumors or Growths [ ]
High Blood Pressure [ ]	Ulcers [ ]
High Cholesterol [ ]	Venereal Disease [ ]
Hives or Rash [ ]	
Hypoglycemia [ ]	
Irregular Heartbeat [ ]	
Kidney Problems [ ]	
Leukemia [ ]	
Liver Disease [ ]	
Low Blood Pressure [ ]	

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 such Dental care to the third party and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. 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 my behalf or my dependents.

Signature of Patient or Legal Guardian _____ Date _____ Relationship to Patient _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

Patient Name_____ Date_____

I acknowledge that I have reviewed the **Notice of Privacy Practices,** which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions that I request.

REFERRAL INFORMATION

If you were referred to our office by another patient or medical office, may we include your name in a thank you letter to them? ____Yes _____No

AUTHORIZATION FOR RELEASE OF INFORMATION

Our office is authorized to release protected health information about patient name above to the entities below.

NAME	RELATIONSHIP	CIRCLE INFORMATION	
_____	_____	Dental	Financial
_____	_____	Dental	Financial
_____	_____	Dental	Financial

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Witness Date

Birkdale Dental

Once this page has been signed, this will be placed in your records as written acknowledgement or receipt of the Notice of Privacy Practices.

OFFICE POLICIES (PLEASE READ IN FULL)

INSURANCE

Our office files insurance **only** as a **courtesy** to our patients. Please be aware that we are not the owners of the policy and it is **your** responsibility to understand your insurance in its entirety. We will initially ask you only for your estimated co-payment but please understand that this is **ONLY AN ESTIMATE** based upon the information available to us by your insurance company. Therefore, the patient/primary policy holder is responsible for **ANY/ALL** unpaid balances. If your insurance coverage lapses or your insurance company denies treatment, it will be your responsibility to appeal and communicate with your insurance company. At that time **all** payments for services rendered will be due. We may assist you in your appeal if desired.

CANCELLATION POLICY

We appreciate you as a patient and have reserved this valuable time just for you. In order to serve our patients better, we cannot accommodate last minute schedule changes. It does not allow us time to offer that appointment to another patient.

LAST MINUTE APPOINTMENT CHANGES WILL BE CHARGED A $75 CANCELLATION FEE. This fee may be charged to your insurance, with the remaining due by you or your responsible party.

PAYMENT OPTIONS

Our office accepts checks, all major credit cards (Visa, Master Card, American Express, and Discover). We also offer an interest line of credit through Care Credit. Please be aware that unless arrangements are made in advance, **PAYMENT IS DUE AT TIME OF SERVICE.**

COLLECTIONS

We understand that situations arise where you are unable to pay your bill. However, we must be able to control our expenses to maintain staff and supplies and keep our fees reasonable. We will send statements at 30, 60, and 90 days, once your insurance has paid any outstanding claims. Once your account is past due 30 days, we will asses a finance charge of 2% per month of the past due balance. Once an account is past 90 days, we will regretfully send your account to collections. Once an account is in collections with our outside collection agency, we will not be able to receive money in our office for payment on your account and we will asses a collection fee equal to that of the collection agency fee.

Signature of Patient or Legal Guardian _____ Date _____