PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you

PERSONAL

Name_____

Address _____ City _____
State _____ Zip_____

Birthdate _____ SS#_____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Work Phone _____ Cell Phone _____ Home Phone _____

Email _____

Preferred contact method [ ] Home Phone [ ] Work Phone [ ] Cell Phone [ ] Email

Preferred contact method for confirmations [ ] Home Phone [ ] Work Phone [ ] Cell Phone [ ] Email
Preferred contact method for recall [ ] Home Phone [ ] Work Phone [ ] Cell Phone [ ] Email

Student status if dependent over 19 (for Ins) [ ] Non student [ ] Fulltime [ ] Part time

How did you hear about us _____
(If someone referred you here, please write down their name so we can thank them.)

Insurance Policy 1

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name _____ Subscriber ID # _____

Subscriber Address _____

Subscriber DOB _____ Subscriber SSN _____

Insurance Company _____ Phone _____

Employer _____ Group Name _____

Group Number _____

Please present insurance card to receptionist.

Insurance Policy 2

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name _____ Subscriber ID # _____

Subscriber Address _____

Subscriber DOB _____ Subscriber SSN _____

Insurance Company _____ Phone _____

Employer _____ Group Name _____

Group Number _____

Authorization for Assignment of Benefits and Submission of Claims

I authorize the health care provider named above to submit claims for payment for services to the health care service plans named below, on my behalf and in my name, and assign to such provider the group insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services. I understand that I am financially responsible for any charges not covered by group insurance benefits.

_____

Health Care Plan #1

_____

Health Care Plan #2

_____

Name of Patient

_____

Signature of Patient, Parent, or Guardian **Date**

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Medical History for New Patients

Today's Date: _____

Last Name: _____ First Name: _____ Date of Birth: _____

Name of Medical Doctor: _____ City/State: _____

Emergency Contact: _____ Contact's Phone: _____

Relationship to Patient: _____

Please List all medications that you are currently taking:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are you allergic to any of the following? If "yes" please check box.

- ☐ Anesthetic
- ☐ Aspirin
- ☐ Codeine
- ☐ Ibuprofen
- ☐ Iodine
- ☐ Latex
- ☐ Penicillin
- ☐ Sulfa drugs

Do you have any of the following medical conditions? If "yes" please check box.

- ☐ Asthma
- ☐ Bleeding Problems
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Murmur
- ☐ Heart Trouble
- ☐ High Blood Pressure
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Pregnancy
- ☐ Psychiatric Treatment
- ☐ Sinus Troubles
- ☐ Stroke
- ☐ Ulcers
- ☐ Rheumatic Fever

Do you smoke or use tobacco? If yes, indicate used type: _____

Have you ever had an unusual reaction to dental injections? _____

Reason for today's visit: _____

New Patient's only:

Have you had a Panoramic X-ray or Full Mouth Set of X-rays that are less than 5 years old? _____

Do you have Bitewing X-Rays that are less than one year old? _____

Former Dentist: _____ City/State: _____ Date of Last Cleaning/Exam: _____

Patient Signature: _____ Date: _____

Authorization for Release of Health Information

I authorize the dentist or other health care provider named above to release to hospital or health care service plans, insurance companies, self – insurers or their representatives, any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to me, that is needed to review, investigate, or evaluate any claim for benefits.

If my coverage is under a group master agreement held by my employer, an association, trust fund, union , or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

This authorization shall remain effective for up to five (5) years from this date. I know that I have the right to receive a copy of this authorization if required.

_____

Name of Patient

_____

Signature of Patient, Parent, or Guardian Date

Visit us on the Web at www.smilealbertville.com

Financial Agreement

- For my convenience, this office may release my information to my insurance company, and receive payment directly from them.
- I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.
- If sent collections, I agree to pay all related fees and court costs.
- Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
- I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.
- I will pay a fee for appointments broken without 24 hours notice.
- Treatment plans may change, and I will be responsible for the work actually done.

Patient Signature _____ Date _____

Notice of Privacy Policies

I have had full opportunity to read and consider the contents of Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

Patient Signature _____ Date_____

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FAMILY & COSMETIC DENTISTRY

James W. Porter II, D.M.D & Jacob L. Turner , D.M.D.

•100 A Andrew Street•Albertville, AL 35950

(256)-878-9200

Failure to Keep Reservations

Our patients are seen on a reservation basis, and we go to great measures to confirm your reservation with our office. Therefore, our office requests at least a 48-hour notice if you will not be able to keep your reservation. If you are unable to give a 48-hour notice, please still contact us as soon as possible. There is usually an "insufficient notice fee" of $75/hour Hygiene appointment and $100/hour for a Dr. appointment for a missed reservation with less than a 24-hour notice.

Failure to notify this office of your inability to keep a reservation can adversely affect your standing as a patient. Should you fail to keep reservations without notifying our office at least 24 hours in advance, please understand that our office will have the right to withdraw from professional attendance upon you.

Your respect for our time and yours is greatly appreciated!

Thank You!

Signature Date