J. M. Bindeman, DDS, PA
General Dentistry

FOR THANK YOU SELECTING OUR DENTAL TEAM

To help us meet all your healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us and we will be happy to help you.

PATIENT INFORMATION (Confidential)

Name_____ Date_____

SS#_____ Birthdate _____ Home Phone _____

Address_____ Cell Phone_____

City_____ State_____ Zip _____ Email_____

Permission to contact ☐ Yes ☐ No

Check appropriate box ☐ Minor ☐ Single ☐ Married ☐ Other

If Student,

Name of School/College_____ City_____ State_____ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer_____ Work Phone_____

Business Address_____ City_____ State_____ Zip_____

Spouse or Parent/Guardian's Name_____ Employer_____ Work Phone_____

Who may we thank for referring you? _____ Contact in Case of Emergency_____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____

Address _____ City _____ State_____ Zip_____

Email_____ Home Phone_____ Cell Phone_____

Driver's License #_____ Birthdate_____ Financial Institution_____

Employer_____ Work Phone_____ SS#_____

Is this Person currently a patient in our Office: Yes ☐ No ☐

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment is expected as services are rendered unless prior financial arrangements have been made.

☐ Cash ☐ Check ☐ VISA ☐ MasterCard ☐ Discover ☐ American Express ☐ Care Credit

DENTAL INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____ Birthdate_____

Name of Insurance Carrier _____ Telephone #_____

Subscriber/Member ID _____ Group #_____

Do you have additional Dental Insurance Coverage ☐ Yes ☐ No If Yes, please complete the following:

Name of Insured _____ Relationship to Patient _____ Birthdate_____

Name of Insurance Carrier _____ Telephone #_____

Subscriber/Member ID _____ Group #_____

FINANCIAL POLICY

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship.

FULL PAYMENT IS DUE AT TIME OF SERVICE unless other arrangements are made **IN ADVANCE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER and AMERICAN EXPRESS.**

REGARDING INSURANCE: Dental insurance is NOT meant to be a PAY ALL, it is meant to be an aid. Many plans tell their insured that they will be covered up to 80% or up to 100%. In spite of what you are told, we have found that most plans cover ONLY about 40% to 50% of an average fee. Some plans pay more and some pay less. The amount your plan pays is determined by the policy you or your employer selected. It has been the experience of many dentists that some insurance companies tell their policyholders that their dentist's fees are above the usual and customary fees rather than telling them that their insurance benefits are low. Some routine dental services are NOT covered by insurance plans. Even with dental insurance YOU are still responsible for the entire cost of our professional services. We will assist you in ESTIMATING your portion of the fees. We accept assignment of benefits. If however, 60 days after submitting a claim, your insurance company has not responded, you will still remain responsible for any balance on your account.

Dental insurance _____ Yes _____ No
If you answered yes, please initial here: _____

LATE CHARGES: If payment is not made within 30 days of treatment, a late charge of 1.5% (18% APR) will be added to your account.

ADULT PATIENTS: Adult patients are responsible for full payment at time of service.

MINOR PATIENTS: The adult accompanying a minor and the parents (or guardians) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, VISA/MasterCard/Discover, or payment by cash or check at time of service.

MISSED APPOINTMENTS: There is a $25 charge for a missed appointment unless canceled or rescheduled at least 24 hours in advance. Please help us serve you better by keeping scheduled appointments.

CONSENT FOR TREATMENT

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis.

2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by him and myself and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Thank you for reading and understanding our Financial Policy and Consent for Treatment. Please let us know if you have any questions or concerns.

Patient_____ Date_____

Parent or responsible party_____

PATIENT MEDICAL HISTORY

Physician: _____ Phone #_____ Date of last exam _____

	Yes	No
Are you under medical treatment now ?	_____	_____
Have you ever been hospitalized for any surgical operation or serious illness in the last 5 years?	_____	_____
If yes, please explain: _____		
Are you taking any medication(s) including non-prescription medicine?	_____	_____
If yes, what medications are you taking? (Please use a separate page if space does not allow for all medication(s).		

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Are you taking any blood thinner medication? (If so, please list name of medication above).	_____	_____
Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	_____	_____
Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	_____	_____
Do you use tobacco?	_____	_____
Do you use controlled substances?	_____	_____
Are you wearing contact lenses?	_____	_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING

	Yes	No		Yes	No
High Blood Pressure	_____	_____	Liver Disease	_____	_____
Heart Disease	_____	_____	Hepatitis/Jaundice	_____	_____
Heart Attack	_____	_____	Epilepsy/Seizures	_____	_____
Cardiac Pacemaker	_____	_____	Arthritis	_____	_____
Heart Valve Replacement	_____	_____	Sinus/Hay Fever	_____	_____
Angina	_____	_____	Diabetes	_____	_____
Low Blood Pressure	_____	_____	Sexually Transmitted Disease	_____	_____
Cancer	_____	_____	AIDS or HIV	_____	_____
Chemotherapy	_____	_____	Glaucoma	_____	_____
Radiation	_____	_____	Stroke	_____	_____
Radiation Therapy	_____	_____	Alzheimer/Dementia	_____	_____
Leukemia	_____	_____	Cold sores/Blisters	_____	_____
Prolonged Bleeding	_____	_____	Stomach problems/Ulcers	_____	_____
Anemia	_____	_____	Kidney Disease	_____	_____
Emphysema/Respiratory Problems	_____	_____	Recent Weight Loss	_____	_____
Tuberculosis	_____	_____	Thyroid Problems	_____	_____
Asthma	_____	_____	Other: _____		
Joint Replacement or Implant	_____	_____			

Do you have a persistent cough not associated with a known illness lasting more than 3 weeks? _____ _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING

	Yes	No		Yes	No
Local Anesthetics (e.g.) Novocain)	_____	_____	Penicillin or any other Antibiotics	_____	_____
Sulfa Drugs	_____	_____	Barbiturates	_____	_____
Sedatives	_____	_____	Iodine	_____	_____
Aspirin	_____	_____	any metals (e.g. nickel, mercury, etc.)	_____	_____
Latex Rubber	_____	_____	Other: _____		

	Yes	No
WOMEN ONLY		
Are you pregnant?	_____	_____
Are you nursing?	_____	_____
Are you taking oral contraceptives?	_____	_____

PATIENT DENTAL HISTORY

Name of Previous Dentist: _____ City: _____

Office Phone: _____ Date of last exam: _____ Date of last cleaning:_____

	Yes	No
Do your gums bleed while brushing or flossing?	_____	_____
Are your teeth sensitive to temperature (hot or cold)?	_____	_____
Are your teeth sensitive to sour liquids/foods?	_____	_____
Do you feel pain to any of your teeth?	_____	_____
Do you have sores or lumps in or near your mouth?	_____	_____
Have you had any head, neck or jaw injuries?	_____	_____
Have you experienced any of the following problems in your jaw?		
Clicking	_____	_____
Pain (joint, ear, side of face)	_____	_____
Difficulty in opening or closing	_____	_____
Difficulty in chewing	_____	_____
Do you have frequent headaches?	_____	_____
Do you clench or grind your teeth?	_____	_____
Do you bite your lips or cheeks frequently?	_____	_____
Have you ever had any difficult extractions in the past?	_____	_____
Have you ever had any prolonged bleeding following extractions?	_____	_____
Have you had any orthodontic treatment?	_____	_____
Do you wear dentures or partial dentures	_____	_____
Date of Placement: _____		
Have you received oral hygiene instructions regarding care of teeth and gums?	_____	_____
Do you like your smile?	_____	_____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information and answered accurately to the best of my knowledge. I authorize the release of information for treatment rendered to me or my child to third party payors and/or health practioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me.

Signature of patient (or parent/guardian if a minor)

Doctor's comments_____

_____

DOCTOR'S SIGNATURE_____ **DATE**_____