HORIZON DENTAL CARE

Welcome! *So that we may provide you with the best possible care, please complete both sides of this medical/dental form. All information is confidential.*

REV 5-2023

Required Patient Information

Patient Name: _____ Date: _____
Last First MI Nickname

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____ Phone (Home): _____

(Cell) _____ (Work) _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment#

_____
City State Zip Code

E-mail Address: _____ How did you hear about us? : _____

Date of last dental visit: _____ Reason for this visit: _____

Have your ever had any of the following? Please check those that apply:

- ☐ Allergies _____ _____
- ☐ Codeine Allergy
- ☐ **Penicillin Allergy**
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ **Diabetes**
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood pressure
- ☐ HIV Positive
- ☐ Jaundice
- ☐ Joint Replacement
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ **Pregnancy** Due date: _____
- ☐ **PRE-MEDICATE**
- ☐ **BLOOD THINNER**
- ☐ **Tobacco**
- ☐ **Alcohol**
- ☐ **Vaping**

OTHER: (explain) _____

- Are you currently under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:

_____

_____

- Please list any medication and vitamins you are currently taking: _____
- In case of emergency, name and phone of person to notify: _____

Parent or Responsible Party Information

If patient is responsible party, please skip this section and go on to Employment Information

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Cell): _____ (Work) _____ Ext: _____

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

(Please complete other side)

Insurance Information

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:_____

_____

Acknowledgement of Receipt of Notice of Privacy Practices

I have received Notice of Privacy Practices for Horizon Dental Care. I authorize the following person(s) to have full disclosure to my Protected Health Information:

Names: _____

_____ _____ _____
Signature Date Relationship to Patient

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for 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 60 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 three 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 certify to the above statements regarding my medical condition to be correct. If I ever have a change in my health, I will inform the doctors at the next appointment without fail.

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

_____ _____ _____
Signature Date Relationship to Patient