

Patient Agreement

Please initial and sign

_____ **As a courtesy to our patients using insurance; we are happy to file claims. All benefits quoted are estimates only and not a guarantee of payment. If you have questions regarding your coverage, please contact your Insurance company directly.**

_____ If insurance coverage is terminated or has not been updated with Modern Dental Care; the patient will be responsible for all incurred charges.

_____ **Modern Dental Care provides the most up to date services. These services include, but are not limited to, composite (tooth colored fillings), same day crowns and cosmetic dentistry. Insurance companies may not cover all procedures. In these cases, the patient will be responsible for any unpaid balances.**

_____ Treatment plans and associated fees may change without notice if It is in the best interest of the patient at the time of treatment.

_____ **All estimated fees are due at the time of treatment. We are happy to discuss finance options. All financial arrangements must be made before any treatment is rendered.**

_____ In the event of a "No Show" or a cancellation within 24 hours of the scheduled appointment, a \$55.00 fee will be billed to the patient.

_____ **Appointments that are over 90 minutes require a non-refundable deposit prior to scheduling. Returned checks are subject to a returned check fee and any bank charges incurred by Modern Dental Care.**

_____ In the event of an emergency after business hours, a \$135.00 emergency fee will be charged in addition to any treatment fees incurred at the time of the emergency visit.

_____ **After sixty days, all outstanding balances will be forwarded to our collection agency.**

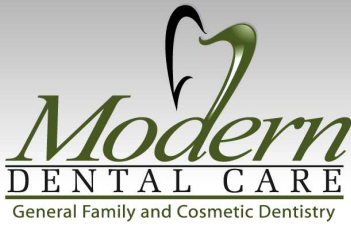
_____ One American dies every hour due to oral cancer. For this reason; we conduct an oral cancer screen using advance technology once per year starting at the second scheduled exam. If your dental insurance does not cover this procedure; the patient will be billed \$20.00.

_____ **I authorize and give consent to Modern Dental Care to perform the dental services agreed between doctor and patient or parent/ guardian to be necessary and advisable including the use of local anesthesia and other medications as indicated.**

I understand that I am ultimately responsible for all services rendered. In the case of default, I am responsible for the cost of attorney's fees, court costs, the cost of collection proceedings and I waive the right to have any amounts owed discharged in bankruptcy.

Date: _____

Signature of patient or legal guardian



Welcome to our office

Patient Name: _____
Last First MI (Preferred name)

Home Address: _____
Street apt#
_____ City state zip

Date of Birth: _____ Social Security#: _____

Gender: Male _____ Female _____ Marital Status: Married _____ Single _____ Child _____
Other _____

Home Phone#: _____ Cell #: _____

Employer: _____ Work #: _____ ext: _____

E-Mail Address: _____ Referred by: _____

Emergency contact: _____ Relationship: _____ Phone#: _____

Insurance Information

Primary Insurance Company: _____ Phone #: _____

Policy Holders name: _____ Are you the patient: Yes _____ No _____

Date of Birth: _____ Social Security #: _____ Id#: _____

Employer: _____ Work#: _____ Ext: _____

Relationship to Insured: Self _____ Spouse _____ Child _____

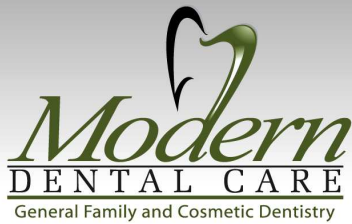
Secondary Insurance Company: _____ Phone #: _____

Policy Holders name: _____ Are you the patient: Yes _____ No _____

Date of Birth: _____ Social Security #: _____ Id#: _____

Employer: _____ Work#: _____ Ext: _____

Relationship to Insured: Self _____ Spouse _____ Child _____



Health Information

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

Do your gums bleed? Yes or No Does your breath concern you? Yes or No

Does floss shred when you use it? Yes or No Have you smoked or chew tobacco? Yes or No

Have you ever had complications following dental treatment? YES _____ NO _____

Please Explain: _____

Why did you leave your last dentist? _____

Do you take or have you ever taken Bisphosphonates (Fosamax, Acetenol, Aredia and Zometa, Etc?)
Yes or No

Women: Are you pregnant? Yes or No Are you Nursing? Yes or No Are you taking Birth Control Pills? Yes or No

Indicate which of the following you have had, or have at present. Circle "Yes" or "No" to each item.

Anxiety	Yes	No	Excessive Bleeding	Yes	No	Low Blood Pressure	Yes	No
Alcohol Abuse	Yes	No	Facial Surgery	Yes	No	Neurological Disorders	Yes	No
Allergies (seasonal)	Yes	No	Fainting Spells	Yes	No	Pacemaker	Yes	No
Anemia	Yes	No	Fever Blisters	Yes	No	Psychiatric Problems	Yes	No
Angina	Yes	No	Glaucoma	Yes	No	Radiation/Chemotherapy	Yes	No
Arthritis	Yes	No	Headaches	Yes	No	Respiratory Problem	Yes	No
Artificial Heart Valve	Yes	No	Head Injury	Yes	No	Seizures	Yes	No
Artificial Joints	Yes	No	Heart Problems	Yes	No	Sensitive Teeth	Yes	No
Asthma	Yes	No	Hemophilia	Yes	No	Sinus Problems	Yes	No
Blood Transfusion	Yes	No	Hepatitis	Yes	No	Stomach Problems	Yes	No
Cancer	Yes	No	Herpes	Yes	No	Stroke	Yes	No
Clenching/Grinding	Yes	No	High Blood Pressure	Yes	No	Thyroid Problem	Yes	No
Congenital Heart Defect	Yes	No	HIV/AIDS	Yes	No	Tuberculosis	Yes	No
Diabetes: Type 1-Type 2	Yes	No	Jaw Pain	Yes	No	Ulcers	Yes	No
Drug Abuse	Yes	No	Kidney Disease	Yes	No	Venereal Disease	Yes	No
Epilepsy	Yes	No	Liver Disease/Jaundice	Yes	No			

Please explain any disease, condition or problem not listed? _____

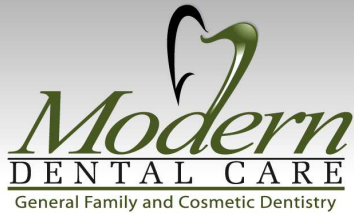
Please list any and all medications you are currently taking including aspirin:

Have you ever had an ALLERGIC REACTION to any of following? Please circle Yes or No:

Aspirin	Yes	No	Latex	Yes	No	Tetracycline	Yes	No
Codeine	Yes	No	Penicillin	Yes	No	Other:	_____	
Dental Anesthetics	Yes	No	Sulfa	Yes	No			

To the best of my knowledge all of the preceding answers and information provided are true and correct. If ever I have any change in my health or medications, I understand it is my full responsibility to notify Modern Dental Care.

Date: _____



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have the opportunity to receive a copy of this
(Please print patients name)
office's Notice of Privacy Practices.

Signature of Patient, Parent or Guardian

Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refuse to sign.
- Communication barriers prohibited obtaining the acknowledgement.
- An emergency situation prevented us from obtaining the acknowledgement.
- Other (please specify)

