Kim Fitzgerald, D.M.D.
Family, Cosmetic & Laser Dentistry
(724) 294-0011
[illegible]

Date _____
Best phone # to be reached for unexpected appointment changes:
_____

Chart #: _____

Patient Information

Patient Name: _____ Birth Date: _____
Last, First MI (Preferred Name)

Gender:____Family Status: _____Social Security #: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Cell phone#1_____Cell phone #2_____E-mail_____

Address: _____
Street Apartment #

_____
City State Zip Code

Referral Information

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

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

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

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Dental Health Information

Reason for today's visit_____Date of last dental care_____

Former Dentist_____Date of last x-ray_____

Circle if you have had problems with any of the following:

Bad breath
Bleeding gums
Clicking or popping jaw
Food collection between the teeth
Grinding teeth
Loose teeth or broken fillings
Sensitivity to cold
Sensitivity to hot
Sensitivity to sweets
Sensitivity when biting
Sores or growths in your mouth
Periodontal treatment Date of treatment_____

Do you like your smile?_____Are you satisfied with the color of your teeth?_____

How often do you floss?_____How often do you Brush?_____

Medical Health Information

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

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

OTHER:

- ☐ _____
- ☐ _____
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Headaches
- ☐ Hemophilia
- ☐ Jaw Pain
- ☐ Mitral Valve Prolapse
- ☐Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Thyroid Problems
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ Tobacco Habit
- ☐ Tonsillitis

List medications you are currently taking and the correlating diagnosis: (**Also please list over the counter ,vitamins & herbs**)

Allergies:

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____

Signature of patient, parent or guardian

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMANTION &CONSENT FOR TREATMENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996(HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out::

- Treatment(including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers(e.g. my insurance company);
- The day to day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

*I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that your are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

***I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.**

_____initials

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash 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.

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

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

Payment Options

To reduce our administrative costs and keep our fees to you as low as possible, we ask that you pay your **estimated** co-payment at the time you receive treatment.

Please indicate below the method of payment you intend to use to pay for your dental treatment, including your co-payment.

PAYMENT OPTIONS

__Cash or check
__Visa/ Mastercard
__Debit
__American Express
__Discover

EXTENDED PAYMENT OPTIONS

__CareCredit

_____
Printed Name of Patient or Responsible Party

_____
Signature of Patient or Responsible Party

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: _____

Assignment for Benefits & Financial Arrangements

**Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to save you time and to facilitate payment to our practice from your insurance company. By having our practice process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.

**We require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our practice.

We require you to pay the **estimated co-payment, which is the amount not covered by your insurance company, at the time we provide service to you. The co-payment is only an **estimate** of charges and may be found to be insufficient after review by your insurance company.

**If your insurance company has not made payment to our practice within 60 days, we ask you to pay the entire balance at that time. If your claim is denied, you will be responsible for paying the full amount.

** This practice will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to resolve questions or confusion.

*****Your insurance is a contract between you, your employer and the insurance company. Any balance not paid by your insurance company is your responsibility and is due within 60 days of treatment.**

We must emphasize that as your dental care providers, our relationship is with you, not with your insurance company. Fees quoted are good for 90 days and are subject to change.

I certify that I, and/or my dependent(s) have insurance coverage and assign directly to this office for all insurance benefits, payable for services rendered.

I have read and accept the terms and above conditions of this assignment of benefits agreement. I authorize my insurance company to pay my dental benefits directly to the practice.

_____ **Date:** _____ **Relationship to Patient:** _____

Signature of patient, parent or guardian