Today's Date_____

Pal Dental Group

Health History

Patient's Name_____Phone_____Cell_____

Name you prefer to be called_____E-Mail Address_____

Home Address _____City_____Zip_____

Occupation_____Employed by_____How long_____

Business Address_____Phone_____

Physician's Name_____Last physical_____

Date of Birth_____Hgt_____Wt_____Male☐Female☐Single☐Married☐Divorced☐Widowed☐

SS No._____Referred by_____

Spouse or Parent (if minor)_____

Responsible Party/Insurance

Person responsible for account_____Phone_____

SS No._____Date of Birth_____

Occupation_____Employed by_____How long_____

Business Address_____Phone_____

Dental Insurance Carrier_____Phone_____

Address_____

Subscriber No._____Group No._____Group Plan_____

Dental History

1. When did you have your last dental exam?_____Dentist's Name_____
2. Was restorative treatment recommended? Yes ☐ No ☐ Completed? Yes☐ No☐
3. How often do you brush your teeth?_____ Do you floss? Yes☐ No☐
4. Do you wear removable appliances? Yes☐ No☐

General Health Questionnaire

1. Are you being treated by a physician at this time? Yes☐ No☐ For what?_____
2. Any drug allergies? Yes☐ No☐ List_____ food allergies _____
3. Do you have or have you ever had any of the following? (check all that apply)

☐ Heart Disease	☐ Kidney Trouble	☐ Tuberculosis
☐ Heart Murmur	☐ Diabetes	☐ Radiation Treatment
☐ Mitral Valve Prolapse	☐ Asthma	☐ Chemotherapy
☐ Pacemaker	☐ Epilepsy	☐ Venereal Disease
☐ Rheumatic Fever	☐ History of Cancer	☐ Sinusitis
☐ Prosthetic Joints	☐ Psychiatric Treatment	☐ Glaucoma
☐ High Blood Pressure	☐ Anemia	☐ Arthritis
☐ Low Blood Pressure	☐ GI Ulcers	☐ AIDS
☐ Bleeding Problems	☐ Severe Pain	☐ Other
☐ Hepatitis	☐ Are you pregnant?_____	
☐ Liver Trouble	☐ Have you reached menopause?_____	

4. List any medications you are currently taking_____

Please understand that as a dental care provider our relationship is with you and not with your insurance company. Filing of insurance claims is a courtesy that we extend to our patients but all charges are your responsibility from the date services are rendered. We have no leverage on assuring that your claims are paid. Our office is not responsible for collecting your insurance claim or for negotiating disputed claims. We invite you to bring your policy booklet with you and we will be happy to assist you in understanding your coverage.

Assignment Authorization / Release of Authorization / HIPAA

I, the undersigned, hereby authorize Pal Dental Group and/or its agents to apply for benefits on my behalf for services rendered to my dependents or me. I request payment from my insurance carrier be made directly to Pal Dental Group and in cases where the carrier had made payments directly to me, I will return funds to Pal Dental Group in a timely fashion. I also certify that the information on this form is correct and further authorize the release of any information for any claim to my insurance carrier. I agree that a copy of this signed release and of my records may be used in lieu of the original and authorize its release to all parties involved in my care and care of my dependents.

In addition, I agree that I have been offered access to Pal Dental Group's **Notice of Privacy Practices** (HIPAA) policies. Written copies are available at my request. *I authorize Pal Dental Group to discuss my medical and/or dental information with the following people (list relationship):*

Guarantee of Payment / Non-Covered Charges

I, the undersigned, understand and agree that I am financially responsible for all charges including those not covered by my dental insurance policy. Payment is due at the time services are rendered. I agree that it is a matter between me and my insurance carrier whether or not the insurance company pays Pal Dental Group all, a portion or none of the claim submitted on my behalf. I understand that if services are denied by my insurance carrier then it is my responsibility to pay for these charges. Regardless of my insurance situation, I understand that I am responsible for any balance due.

In the event that my account must be placed with an attorney or collection agency, I agree to pay attorney fees in the amount of thirty three and one third percent of the unpaid balance, any court costs and interest in the amount of eighteen percent per annum.

I further understand that I will be charged $75 for every scheduled appointment hour that I cancel or miss without giving 24 hours notice.

Signature of Patient or Responsible Party_____ Date_____
(parent or guardian if patient is a minor) (SEAL)