

WELCOME TO CASELLE DENTAL - TELL US ABOUT YOURSELF

Patient's Name _____ Date _____
Last First MI

Preferred Name _____ Male Female Married Single Child Other

Address _____ City _____ State _____ Zip _____

Social Security # _____ Birth Date _____ E-mail _____

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

Employer Name _____ Occupation _____

Address: _____
Street City State Zip

How do you prefer to be contacted for appointment confirmation? _____

◆ Person Responsible for Payment (if other than patient)

Name: _____ Male Female Married Single Other _____

Social Security # _____ Birth Date _____ E-Mail _____

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

Address _____ City _____ State _____ Zip _____

Employer Name _____ Occupation _____

Address: _____
Street City State Zip Code

◆ Insurance – Primary

Name of Insured _____ Is insured a patient? Yes No

Insured's Birth Date _____ ID # _____ Group # _____
Last First MI

Insured's Address _____ City _____ State _____ Zip _____

Insured's Employer Name _____
Address _____

Patient's relationship to insured Self Spouse Child Other _____

Insurance Plan Name and Address _____

◆ Insurance – Secondary

Name of Insured _____ Is insured a patient? Yes No

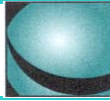
Insured's Birth Date _____ ID # _____ Group # _____
Last First MI

Insured's Address _____ City _____ State _____ Zip _____

Insured's Employer Name _____
Address _____

Patient's relationship to insured Self Spouse Child Other _____

Insurance Plan Name and Address _____



PATIENT _____ DOB _____

Medical History

Do you have or have you ever had any of the following? Please check those that apply.

- Grid of medical conditions with checkboxes: Allergies, Anemia, Angina, Arthritis, Artificial Heart Valve, Artificial Joints, Asthma, Blood Transfusion, Cancer, Chemotherapy, Congenital Heart Defect, Diabetes, Dizziness, Emphysema, Epilepsy, Excessive Bleeding, Facial Surgery, Fainting, Frequent headaches, Hay Fever, Heart Attack, Heart Disease, Heart Murmur, Hemophilia, Hepatitis - Type, High Blood Pressure, HIV / AIDS, Joint Replacement, Kidney Disease, Liver Disease, Low Blood Pressure, Migraines, Mitral Valve Prolapse, Pacemaker, Psychiatric Problems, Radiation Therapy, Respiratory Problems, Rheumatic Fever, Rheumatism, Sexually Transmitted Disease, Shingles, Sinus Problems, Stomach Problems, Stroke, Thyroid Problems, Tuberculosis, Ulcers. Includes boxes for 'Allergies To Medications' and 'Women only: Pregnancy'.

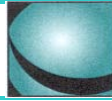
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain:
• Are you now under the care of a physician? Yes No
If yes, please explain:
• Name of Physician Phone
• Do you have any health problems that need further clarification? Yes No
If yes, please explain:
• List any medications you are taking (if none write NONE):

Nearest relative not living with you:
Name Relationship
Address Phone

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 agree to inform the doctor at the next appointment.

Signature of patient, parent or guardian Date

- How did you hear about our office? Another patient Internet Insurance Company
Dental Office Verizon Yellow Pages Community Yellow Pages Newspaper Work Other
Name of person or office referring you to our practice
Date of Last Dental Visit Reason for this visit
• If you could change one thing about your smile what would it be?
• If there was a simple inexpensive way to whiten your teeth would you be interested? Yes No
• Why did you leave your last dentist?
• What did you like most about any dentist you have ever seen?
• Have you ever had any complications following dental treatment? Yes No
If yes, please explain:



Consent for Services & Authorizations

- As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patient for the costs incurred in their care and the 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 at the time services are performed. We accept MasterCard, Visa, American Express, Discover, cash, and checks. If you are in need of an extended finance option, we work with CareCredit, which offers short term interest free programs or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit. Ask for details.
- If you have a Dental Plan please know that it is designed to help you pay for a portion of the cost of your dental care. Therefore, patients who have dental insurance should understand that all dental services provided are charged directly to the patient and that he or she is personally responsible for payment of all dental services. Our office will prepare insurance forms and assist in obtaining payment from your insurance company on your behalf and will credit any such payments to your account. Please understand our dental office cannot render services on the assumption that our charges will be paid by your insurance company.
- Insurance eligibility and benefits quoted are not a guarantee, they are subject to change. We will provide you with an estimate of your co-payments and deductible based on your insurance coverage which is payable at the time of your visit. This ESTIMATE IS NOT A GUARANTEE of the final amount of benefits to be paid by your insurance company. The final amount of benefits to be paid will be determined by your insurance company only after they receive the dental claim. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.
- The amount your plan pays is determined by the agreement negotiated by your employer with the insurer and by how much your employer contributes to the plan.
- As a service to you, we will submit your dental claims to your insurance company. Keep in mind that dental plans are designed to share in the cost of your dental care, not to completely pay for those costs. Please ask for "Why Doesn't My Insurance Pay for This?" pamphlet at the front desk which will answer any other questions you may have about dental insurance
- I further agree to pay for all services rendered regardless of anticipated insurance benefits within 30 days of the date of service and agree to pay all reasonable attorney fees or collection costs associated with non-payment of an account balance.
- A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days regardless of anticipated insurance payments.
- I authorize the release of any information including the diagnosis and records of treatment or examination rendered to either myself or a dependent to my insurance company and/or healthcare practitioner. I authorize and request that my insurance company pay directly to the doctor insurance benefits otherwise payable to me.
- **I have read the above conditions of treatment and agree to their content.**

▶ _____ Date: _____ Relationship to Patient: _____
 Signature of patient, parent or guardian

▶ _____ Date: _____ Relationship to Patient: _____
 Signature of person responsible for payment other than patient