New Patient Information

First _____ MI _____ Last _____

Preferred Name _____ Date of Birth _____

Address_____

City_____ State _____ Zip Code _____

Marital Status _____ Social Security # _____

Employer_____ Occupation _____

Home# _____ Work#_____ Cell#_____

Email address_____

Preferred contact to confirm appointments: _____ Text _____ Email

Emergency contact name _____ Phone _____

How did you hear about our office? _____

Person Financially Responsible for Account_____ DOB_____ Relationship_____

I give Coastal Family Dentistry, PA, permission to talk about all of my dental and financial records/needs to the following person(s) _____.

Insurance information

Primary insurance policy holder's name_____ DOB_____

Policy holder's Social Security#_____ Employer_____

Insurance Company _____Subscriber ID# _____ Group#_____

Secondary insurance policy holder's name_____ DOB_____

Policy holder's Social security#_____ Employer_____

Insurance Company _____Subscriber ID# _____ Group#_____

I understand that payment is required for all services rendered on the date of service unless other arrangements are made in advance and that my insurance will be filed for me as a courtesy service. I hereby authorize the dental office to release all information necessary to secure the payment of benefits directly to the office, unless other arrangements have been made. I understand that I am responsible for ALL charges whether or not they are covered by insurance benefits.

Signature_____ Date_____

** Your appointment is reserved for you. Please provide at least **2 business days notice** should you need to change your reserved appointment time or a broken appointment fee of **$50** will be charge.**

Patient Name: _____

Date of Birth: _____

Welcome to our office! So that we may provide you with the best possible care, please complete this form. All information is completely confidential.

MEDICAL HISTORY

Physician's Name_____ Date of last physical: _____/_____/_____

(Women) Are you pregnant? ____ Yes ____ No Nursing? ____ Yes ____ No Taking Birth Control? ____ Yes ____ No

LATEX ALLERGY? ____ Yes _____ No

Any Premedication's needed for appointment ___Yes ____ No (Heart, Artificial joints, etc)

If Yes, Please list name and current dosage of medication: _____

Do you smoke/chew tobacco or use other tobacco products? ___ Yes ___ No If yes, which one?_____

Please check if you have/had any of the following:

__ A.I.D.S.	__ Glaucoma	__ Pacemaker
__ Anemia	__ Heart Murmur	__ Psychiatric care
__ Artificial Joints	__ Heart Problem	__ Radiation Treatment
__ Asthma	__ Hemophilia	__ Respiratory Disease
__ Cancer	__ Hepatitis A B C (Circle)	__ Seizures
__ Chemotherapy	__ High Blood Pressure	__ Sleeping disorders/Snoring
__ Chronic Cough	__ H.I.V. Positive	__ Stroke
__ Diabetes	__ Kidney Disease	__ Thyroid Disease
__ Epilepsy	__ Liver Disease	__ Tuberculosis
__ Fainting	__ Mitral Valve Prolapse	__ Venereal Disease

List any allergies with reactions:

_____

_____

_____

List any medications you are currently taking:

_____ _____ _____

_____ _____ _____

_____ _____ _____

DENTAL HISTORY (NEW PATIENT'S ONLY)

What is the reason for your visit today?_____

Date of Last Dental Visit _____ Last Cleaning _____ Last Full Mouth Xrays _____

Previous Dentist's Name _____ Phone number _____

Previous Dentist's Address _____

Any other dental concerns? _____

Patient Name _____

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to treatment.

APPLICABLE PAYMENT IS DUE AT THE TIME OF SERVICE

Forms of payment:

We accept cash, checks, American Express, Discover, Visa, MasterCard, and Care Credit.

Returned checks:

There is a $30 returned check fee on all returned checks.

Insurance:

We may accept assignment from your insurance benefits. However, it is **your responsibility**. If your insurance has not paid in full within 45 days, you are responsible for full payment of your account. All co-pays and deductibles are due at the time of treatment. This amount may be an estimate based on the information provided by your insurance company. Because this is an estimate, there may be additional fees unknown to the office team, resulting in a balance on your account.

Missed appointments:

Your appointment time has been reserved for you. We understand that unforeseen events may happen. However, unless cancelled at least **2 business days** in advance, our policy is to charge for missed appointments at the rate of **$50.00** per office visit. If you (we) are able to fill your appointment with another family member or friend, you will not be charged the $50.00 missed appointment fee.

Thank you for understanding our policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

_____ _____

Signature Date

NOTICE OF PRIVACY PRACTICES

I have read or received a copy of the Notice of Privacy Practices for Coastal Family Dentistry, PA.

_____ _____

Signature Date

FOR OFFICE USE ONLY

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

_____. Office Signature _____