Patient Information

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

Gender: F / M E-mail address: _____

Social Security #: _____ Birth Date: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Date of Last Dental Visit: _____ Purpose for this Appointment: _____

What medications are you currently taking_____

Why did you leave your last dentist _____

Name of your previous dentist: _____City_____Phone_____

Symptoms: **"Are you experiencing any discomfort or sensitivity?"**

- ❑ How long?_____Where?_____
- ❑ Swelling
- ❑ Mobility (loose)
- ❑ Pain on pressure
- ❑ Hot or cold
- ❑ Bleeding Gums
- ❑ Broken Tooth
- ❑ Accident_____
- ❑ Taking Pain Medication What? _____ How Often?_____

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

☐ AIDS
☐ Allergies _____
_____
☐ 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 A, B or C
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnant
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers

☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy

☐ Latex Allergy
OTHER:
☐ _____

Billing Information

Name: _____ Relation to patient, if not self: _____

Address (if different than patient): _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Subscriber: _____ Is subscriber a patient? ☐ Yes ☐ No
Last First MI

Subscriber's Birth Date: _____ ID #: _____ Group #: _____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and phone: _____

Secondary

Name of Subscriber: _____ Is subscriber a patient? ☐ Yes ☐ No
Last First MI

Subscriber's Birth Date: _____ ID #: _____ Group #: _____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and phone: _____

Financial Policy

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 that you read and sign.
As a courtesy to you we will submit all insurance claims to your insurance provider. We will provide an estimate of the portion that your insurance will cover. However, it is NOT a guarantee that your insurance will pay exactly as estimated. We will of course, do all we can to make sure our estimate is accurate as possible. All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Our office is not a party to that contract. If payment is not received after 60 days on any claim that is denied by your insurance company, you the patient will be responsible for paying the full amount.
I authorize insurance payment to be made directly to Dr. Storer. I understand that I am responsible for any portion not covered my dental plan.

FINANCIAL CHARGES: All returned checks are subject to a $25 fee. All balances over 90 days are subject to interest in the amount of 12% annum.
PAST DUE ACCOUNTS: In the event that your account is left unpaid we will report it to all 3 major credit bureaus and assign it over to a Collection Agency.

I have read, understand, and accept the terms of the aforementioned financial policy:

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

Both parties are responsible for paying the debt, but may, depending, on their divorce decree, sue the non-paying party for the obligation that has been paid. Our policy is not to get involved in the divorce decree itself. We explain the obligations of both mother and father and that the decree is between them. This helps focus direction back on the bill being paid.

- 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: _____

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Insurance ☐ Yelp ☐ Google ☐ Other _____

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

I authorize the release of my dental records from Dr. Kirk Storer to individuals involved in my dental care.

I am aware that if I do not provide 2 working days notice (weekends and Mondays do not count) to change my appointment, I maybe charged a fee of **$75. Our office hours are Mondays-closed, Tues., 9-6, Wed., 8-5, Thurs., 9-6 & Fridays 7-2**

I am aware of and have received notice of the Health Insurance Portability & Accountability Act (HIPPA)

Appointment Reminders:

Our office uses a software program to confirm your dental appointments. This software will send out appointment reminders via Text messages and E-mail. The benefits of e-mail and text are being able to read the messages at your convenience without the interruption of a phone call. We understand that your time is valuable and it's sometimes challenging to receive our calls.
If you DO NOT want reminders with this method please check here _____

Authorization and Consent To Send Unencrypted Patient Information by Email and Other Electronic Means

I authorize Park Place Dental, Kirk Storer DDS MAGD to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for treatment, or Park Place Dental health care operations. The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment, and payment records.

If I choose to stop this method, I can do so by writing to stop emailing my patient information at any time. It will not affect emails that Park Place Dental, Kirk Storer DDS MAGD already sent before receiving my written instructions to stop.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____Date_____

Signature