Patient Information Form

Patient Information

Name ________________________ DOB____/____/_____ SS #______-____-______
Address_____________________________ City____________ State____ Zip_________
Cell Phone #_____________ Home Phone #_____________ Work Phone #______________
Check Appropriate Option: __Single __Married __Divorced __Widowed __Separated __Minor__
Patient or Parent's Employer _________________ Employer Address____________________
Spouse or Parent's Name____________________ Employer__________ Work #__________
To Whom May We Thank for Referring You To our Practice? ___________________________
Person Of Contact in Case of Emergency________________________ Phone #____________

Responsible Party

Name of Person Responsible for this Account________________ Relation of Patient _________
Address____ Phone #___________________
DOB____/___/_____ Driver's License #_____________________ Bank__________________
Employer_________________________ Work #___________________
Are you currently a patient in our office? Yes__ No__

Insurance Information

Name of Insured__________________________ Relation to Patient_____________________
DOB____/___/____ SS #_____-___-_____ Employer_________________________________
Employer Address_________________________ City____________ State___ Zip_________
Work Phone #________________________ Dates Employed__________________________
Insurance Company__________________ Group #________________ Union or Local_______
Address________________________ City_______________ State____ Zip_______________
How Much is Your Deductable?_____________ How Much Have You Used?_____________
Max. Annual Benefit_____________________

Additional Insurance

Name of Insured__________________________ Relation to Patient_____________________
DOB____/___/____ SS #_____-___-_____ Employer_________________________________
Employer Address_________________________ City____________ State___ Zip_________
Work Phone #________________________ Dates Employed__________________________
Insurance Company__________________ Group #________________ Union or Local_______
Address________________________ City_______________ State____ Zip_______________
How Much is Your Deductable?_____________ How Much Have You Used?_____________
Max. Annual Benefit_____________________

Health History

Patient Name________ Age______ Today's Date____________
Primary Care Physician_____________________________ Phone #__________________
Current Physical Health ___Good ___Fair ___Poor
Are you currently under a physician's care? ___ Yes ___No

List all prescriptions and over the counter medications you take:
____ ____
____ ____
____ ____

List any allergies:
____ ____
____ ____
____ ____

Please CHECK if you have any of the following:

__A.D.D./A.D.H.D.
__Anemia
__Arthritis
__Artificial Joints
__Artificial Heart Valve
__Asthma
__Back Problems
__Blood Transfusion
__Chemotherapy
__Colitis
__C.O.P.D.
__Crohn's
__Circulatory Problems
__Chemical Dependency
__Cortisone Treatment
__Cough, Persistent

__Drug/Alcohol Abuse
__Emphysema
__Epilepsy
__Fainting Spells
__Fever Blisters
__Glaucoma
__Heart Defect
__Heart Murmur
__Heart Surgery/Stent
__Hemophilia/Abnormal Bleeding
__Hepatitis A B or C/Liver Disease
__High Blood Pressure
__H.I.V./A.I.D.S
__Kidney Disease
__Low Blood Pressure
__Mitral Valve Prolapse

__Psychiatric Problems
__Radiation Therapy
__Rheumatic/Scarlet Fever
__Respiratory Disease
__Seizures
__Shortness of Breathe
__Skin Rash
__Swelling of Feet or Ankles
__Severe/Frequent Headaches
__Shingles
__Sinus Problems
__Smoker- Packs a day___
__Stroke
__Thyroid Problems
__Tuberculosis
__Difficulty Breathing

__Take Aspirin or Blood Thinners daily
__Pregnant
__Nursing
__Birth Control Pill
__Ulcers
__Pacemaker
__Tonsillitis
__Diabetes
__Kidney Disease
__Nervous Problems

Dental Health
When was your dental visit?___________________________
When was your last full set of x-rays and cleaning?____________________
Do you have any TMJ issues?____________
Do you have to take antibiotics before your dental appointments?___________
Are you happy with your smile?________________
What are your concerns today?____

Authorization and Release
I have read, understand, and attest to the accuracy of the above information on this page. I understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes to my medical status.

Signature_________________________ Relationship to Patient_____________________________

Date___________________________ Doctor's Signature________________________________

Dr.’s Benner and Townsend Dentistry

Insurance/Financial Policy and Release Form

Your insurance is a contract between you, your employer, and the insurance company. As a courtesy, we are happy to file your primary and secondary insurance claims. Based on the information provided by your insurance company to us, we will be able to ***estimate*** your portion for any treatment needed. This is in no way a guarantee off insurance payment and you are ultimately responsible if insurance denies your claim for any reason. We will gladly discuss your proposed treatment, file a predetermination with your insurance and answer any questions you may have.

Payment is due at the time services are rendered.

We will be happy to file your insurance claims; however, your estimated portion is due when services are rendered. 90 days after treatment is rendered, you are responsible for your account balance regardless of status of insurance payment.

We accept CASH, CHECKS, VISA, MASTERCARD, and DISCOVER
*We have financing options with CARE CREDIT
-Any returned checks are subject to an additional fee
-Accounts over 90 days past due may be turned over to a collection agency
-There will be a $30 “Broken Appointment Fee” charged to your account for appointments cancelled without a 24 hour notice and for a No-Show Appointment

I understand that I am responsible for all Collection, Attorney, and Court Cost incurred in Collection of my account.
I hereby authorize payment of Insurance Benefits directly to Dr’s Benner and Townsend Dentistry, Dr. Mark P. Benner DDS, PC and Dr. Cyndie K. Townsend, DMD, PC. I authorize the release of any dental information necessary to process dental claims.

Signature______________________________________ Date_____________________

RELEASE

I authorize the dentist and staff to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I authorize release of any information concerning my (or my child’s) health care, advice and treatment to another treating dentist, specialist or doctor.
I have read, understand, and attest to the accuracy of the information on this page.

Signature______________________________________ Date_____________________

Dr.’s Benner and Townsend Dentistry

Acknowledge of Receipt of Notice of Privacy Practices (HIPPA)

*You may refuse to sign this Acknowledgment

I,______________________,have reviewed/received a copy of this office’s Notice of Privacy Practices.

Print Name_____________________

Signature______________________

Date____________________

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our notice of privacy practices, but acknowledgment could not be obtained because:

__Individual refused to sign

__Communication barriers prohibited obtaining the acknowledgment

__An emergency situation prevented us from obtaining acknowledgment

__Other, specify:____