JAMES D. ALCORN

family dental care

We are please to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date: ____________________ Social Security # _____ - ______ - _____

Patient: ____
LAST FIRST MI

Address: ____________________________________ Home: ( ) ____________

____________________________________ Work: ( ) ____________
CITY STATE ZIP

Sex: ☐ Male ☐ Female Age: ________ Birth Date: ________________

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Child

EMPLOYMENT INFORMATION

Employer Name: ________________________ Phone: ( ) ____________

Address: ____________________________________ Occupation: ______________

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CITY STATE ZIP

EMERGENCY CONTACT (Specify someone who does not live in your household)

Name: __________________________ Relationship: __________________________

Home: ( ) __________ Work: ( ) __________

DENTAL INSURANCE INFORMATION

Insured's Name: ______________________________ Is insured a patient? ☐ Yes ☐ No
LAST FIRST MI

Insured's Birth Date: ____________ SSN#: ____________________

Group Plan: ______________________ Group # __________________

Insurance Company: ______________________ Insurance Phone: ( ) __________

Insurance Address: ____
STREET CITY STATE ZIP

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other __________________

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? __________________________________

☐ Another Patient ☐ Yellow Pages ☐ Dental Office ☐ Other ______________________

Patient Name ______________________________

DENTAL HISTORY

Other family members seen by us? ____________ Current/Past Dentist? ____________

What qualities do you look for when choosing a dentist? ____________

Why did you leave your last dentist? ____________

If you could change anything about your smile, what would it be? ____________

Are you currently in pain? □ yes □ no If yes, describe: ____________

Do you ever have pain in your jaw joint? □ yes □ no Do your gums ever bleed? □ yes □ no

Any problems with past dental work? □ yes □ no Describe: ____________

MEDICAL HISTORY

Do you have a personal physician? □ yes □ no Physician's name: ____________

Have you ever had a serious head or neck injury? □ yes □ no Have you been hospitalized in the past two years □ yes □ no

Are you in good health? □ yes □ no If no, why? ____________

Have you ever taken Phen-Fen or Redux? □ yes □ no Are you taking any over-the-counter/prescription drugs? □ yes □ no

If yes, list: ____________

Women: Are you pregnant □ yes □ no Nursing □ yes □ no Taking oral contraceptives □ yes □ no

AIDS/HIV	□	Chest Pain	□	Kidney Problems	□
Artificial Joints*	□	Congenital Heart Defect	□	Severe/Frequent Headaches	□
Artificial Heart Valves*	□	Heart Attack	□	Shingles	□
Anemia	□	Heart Murmur*	□	Sinus Problems	□
Arthritis/Rheumatism	□	Heart Surgery/Pacemaker*	□	Shortness of Breath	□
Asthma/Allergies	□	Tumor history	□	Smoke or Chew Tobacco	□
High Blood Pressure	□	Jaundice	□	Tuberculosis	□
Low Blood Pressure	□	Nervous/Anxious	□	Ulcers/Colitis	□
Blood Transfusion	□	Hemophilia	□	Venereal Disease	□
Cancer/Chemo/Radiation	□	Excessive Bleeding	□	Scarlet Fever	□
Diabetes	□	Hepatitis-Type:_____	□	Psychiatric Care	□
Drug/Alcohol Abuse	□	Mitral Valve Prolapse*	□	Swelling of Feet or Ankles	□
Emphysema	□	Rheumatic Fever	□	Swollen Neck Glands	□
Epilepsy/Seizures	□	Stroke	□	Respiratory Disease	□
Fainting Spells	□	Thyroid Disease	□	Bruise Easily	□
Fever Blisters/Cold Sores	□	Tonsilitis	□	Anaphylaxis	□
Glaucoma	□	Liver Disease	□	Blood Disease	□

*May require medication

Are you allergic to any of the following? Penicillin □ Other Antibiotics □ Local Anesthetics □ Codeine □ Latex □ Aspirin □ Metal □ Iodine □ Barbituates (sleeping pills) □ Other: ____________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing inaccurate information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status

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SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

JAMES D. ALCORN

family and cosmetic dentistry

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality of lifetime dental care. In an effort to better serve you, please review our appointment, insurance and financial policies

APPOINTMENTS

We will do our best to schedule your appointment at a convenient time. 24 hour notice is required if you are unable to keep your scheduled appointment. Appointments are confirmed by phone whenever possible. If we are unable to reach you, we trust that you will keep your appointment. If a patient arrives more than 10 minutes late, we reserve the right to reschedule the appointment.

INSURANCE

As a courtesy to you, we will file your claims with your primary insurance company. We will try to answer any questions that you may have about your insurance, however, as your dental care provider, our relationship is with you, our patient, and not with your insurance company. We will provide an insurance estimate to you, however, it is not a guarantee that your insurance company will pay exactly as estimated. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We ask that you pay the deductible and co-payment amounts which is the estimated amount not covered by your insurance company at the time service is provided. If your insurance company has not made payment within 60 days, we ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

FINANCIAL

Please understand that payment is due at the time service is provided. Our office accepts cash, personal checks, Visa, MasterCard, Discover, and American Express. We also offer outside financing through Care Credit for patients who wish to make monthly payments (upon approval); applications are available upon request. Please ask if you would like more information about financing options. Returned checks will be charged a fee of $25. In accordance with the Federal Truth-in-Lending Act, any balance older than 60 days will be subject to a billing charge of $5 per month or 21% APR, whichever is greater.

AUTHORIZATON, ASSIGNMENT and GUARANTEE OF PAYMENT

I hereby consent to any dental treatment procedures, deemed necessary and desirable for any condition found on examination, or for any condition which may later become apparent during treatment. I authorize Dr. Alcorn and/or such staff members (associates, assistants, hygienist) as he may designate to perform those procedures as may be deemed necessary for treatment. I consent to the administration of anesthetic agents for my dental treatment. I understand that the administration of local anesthetic may cause a reaction or side effect, which may include, but are not limited to, bruising, cardiac stimulation, temporary or rarely permanent numbness, and muscle soreness. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions. I hereby assign and authorize payment of insurance benefits directly to Dr. James D. Alcorn. I will be financially responsible for all services and guarantee payment of charges incurred on my behalf. In the event payment under this agreement is not made at the time and in the manner required, the undersigned agrees to pay all costs of collection, including attorney fees, court costs, filling fees, or attorney retained to pursue this matter, with or without suit. I authorize the gathering of credit information needed for my account.

SIGNATURE____ DATE_______________________________

Patient, Legal guardian, or authorized agent of patient

WITNESS____ DATE_______________________________

HIPPA Privacy Policy

We are required by law to maintain the privacy of your health information. You have the right to obtain a copy of our Notice of Privacy Policies directly from our office at any time. By signing below you acknowledge you have reviewed and understand these policies.

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______________________________	______________________________
Print patient name or names	Patient signature, Legal guardian or authorized representative