Dr. James D. Alcorn, DMD

Date: _____ How did you hear about our office? _____

Patient Name: _____Birthday: _____Email:_____

Home Address: _____City: _____State: ____Zip: _____

Cell Number: _____Work Number: _____Home Number: _____

Would you prefer text reminder_____, email reminder_____, or phone reminder_____

Social Security Number: _____ Occupation: _____ Employer: _____

Spouse's Name: _____Spouse's Birthday: _____Spouse's work Number: _____

Emergency contact name & phone number _____

Dental Insurance: _____Group or Plan #: _____

Policy Holder: _____ Policy Holder Date of Birth: _____

Dental History

Do you have any dental pain? _____Where? _____

When did the pain start? _____When was your last dental visit? _____Where? _____

Have you ever had a severe reaction to a dental treatment? _____If yes, explain: _____
_____Have you ever had gum disease? _____

Medical History

Are you in good health? _____If no, explain: _____

Do you have an existing illness? _____If yes, explain: _____

Have you been hospitalized in the past two years? _____If yes, explain: _____

Do you bleed excessively when cut? _____Do you smoke? _____If yes, how much? _____

Are you taking any medication or drugs? _____If yes, please list the NAMES of the medications and also the REASON for taking them: _____

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING (please circle appropriate answer)?

Heart (Surgery, Disease, Stroke)	Yes No	Radiation Treatment	Yes No	Epilepsy or Seizures	Yes No
High Blood Pressure	Yes No	Chemotherapy	Yes No	Fainting or Dizzy	Yes No
Stroke	Yes No	Venereal Disease	Yes No	Nervous/Anxious	Yes No
Chest Pain	Yes No	Kidney Disease	Yes No	Psychiatric/Psychological Care	Yes No
Artificial Heart Valve	Yes No	Cortisone Medication	Yes No	Asthma	Yes No
Heart Pacemaker	Yes No	Artificial Joints (Hip/Knee)	Yes No	Tuberculosis	Yes No
Mitral Valve Prolapse	Yes No	Ulcers	Yes No	Glaucoma	Yes No
Swollen Ankles	Yes No	Thyroid Problems	Yes No	Hepatitis (If yes, put type_____)	Yes No
Blood Disease	Yes No	Hay Fever	Yes No	Pregnant (Due when_____)	Yes No
Rheumatic Fever	Yes No	Sinus Trouble	Yes No	Allergies	
Heart Murmur	Yes No	Sickle Cell Disease	Yes No	Penicillin	Yes No
Diabetes	Yes No	Cold Sores/Fever Blisters	Yes No	Other Antibiotics	Yes No
HIV Positive	Yes No	Hemophilia	Yes No	Metals	Yes No
A.I.D.S	Yes No	Bruise Easily/Blood Thinners	Yes No	Latex Sensitivity	Yes No
Arthritis/Rheumatism	Yes No	Liver Disease	Yes No	Local Anesthetic	Yes No
Tumor History	Yes No	Yellow Jaundice	Yes No	Others	Yes No

HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED: I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

SIGNATURE: _____ DATE: _____
(Patient, legal guardian, or authorized agent of patient)

OVER

PATIENT'S NAME: _____

FINANCIAL AGREEMENT: Please indicate your choice of payment below:

In order to control the cost of billing, we request that charges for office visits be paid at the time of service, unless prior arrangements have been made with our Business Manager.

A. _____ Payment in full as treatment begins.
   a. _____ Cash or Check (5% discount if paid in full on the day of treatment).
   b. _____ Credit Card (3% discount if paid in full on the day of treatment).
B. _____ Insurance – you are responsible for any balance not covered (After 90 days the full office fees become your responsibility).
C. _____ Financial arrangements upon approval through Care Credit.com

Authorization, Assignment, and Guarantee of Payment:

I hereby consent to any medical or surgical treatment rendered to me and guarantee payment of charges incurred on my behalf. I hereby assign and authorize payment of insurance benefits directly to Dr. James D. Alcorn. I will be financially responsible for all services. In the event payment is not made at the time and in the manner required, the undersigned specifically agrees to pay all reasonable attorney fees and court costs in the event legal action is taken to collect on the account. The undersigned further agrees to pay an additional amount representing thirty-five percent (35%) of the principal balance if the account is referred to a collection agency or attorney for collections. This additional amount is in recognition of the costs associated with said collection action processing. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc., to the dentist's collection agency or collection attorney should collection procedures as described become necessary. I also hereby agree to pay a finance charge of 1 ½ % per month (18% annum) on the unpaid balance.

I authorize Dr. James D. Alcorn and/or such associates or assistants as he/she may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health, or the dental health of any minor or other individual for which I have responsibility. This includes arrangement and/or administration of any sedative (including nitrous oxide), analgesic therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to: bruising, hematoma, cardiac, simulation, and temporary or, rarely, permanent numbness, and muscle soreness. I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. 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 certify that I have answered all questions on both sides of this form accurately and to be best of my knowledge. I hereby agree to abide by the conditions outlined herein.

Signature _____ Date _____
(Patient, Legal guardian or authorized agent of patient)

Witness _____ Date _____