PLEASE FILL OUT ALL INFORMATION COMPLETELY

PATIENT INFORMATION (required)

Patient's Name: _____ Birthday_____ Sex: M F
Last First Initial

Address _____City _____ State _____ Zip _____

Occupation _____ Email Address _____ @ _____

H Phone _____ B Phone _____ Mobile_____

Driver's License # _____Social Security #_____

FINANCIALLY RESPONSIBLE PARTY IF DIFFERENT THAN ABOVE (required)

Name: _____Relationship: _____ Birthday _____

Driver's License # _____Social Security #_____

Address _____ City _____ State _____Zip_____

Phone _____Bus. Phone _____Ext _____ Mobile_____

EMPLOYER (required)

Employer Name _____

Address _____City _____ State _____ Zip _____

Phone _____ Ext _____ Department _____ Employed Since _____

SPOUSE (required)

Name of Spouse _____ Birthday _____

Employer _____

Address _____City _____ State _____ Zip _____

Phone _____Ext_____ Department _____ Employed Since _____

EMERGENCY CONTACT INFORMATION (required)

Name of Relative _____ Relationship _____

Address _____City _____ State _____ Zip _____

Phone _____ Bus. Phone _____ Ext_____ Mobile _____

REFERRAL INFORMATION (required)

Name of referring party _____ Phone _____

INSURANCE INFORMATION (required)

Primary Carrier _____ Address _____

Phone _____ Subscriber _____ Contract #_____Group # _____

Secondary Carrier _____ Address _____

Phone _____ Subscriber _____ Contract #_____Group # _____

FINANCIAL REPONSIBILITY

This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection in the event of default. I further understand that if a payment becomes 90 days past due, 30% of the balance will be charged to my account to cover collection costs. A 7% annual interest rate will be applied to this balance.

Signature _____ Date _____

DID YOU FILL OUT ALL INFORMATION?

Revised April 24, 2006

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address: | **Today's Date:** | **Date of Last Visit:** | **Date of Med. History:**

City State Zip: | **Email:**

Home Phone: | **Work Phone:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

Primary Dental Guarantor: | **Home Phone:** | **Work Phone:**

Secondary Dental Guarantor: | **Home Phone:** | **Work Phone:**

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks ☐
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke or use tobacco?

Height: ☐

For Office Use Only
BP ☐ Heart Rate: ☐

Weight: ☐

Y N	Conditions
☐ ☐	Abnormal Bleeding
☐ ☐	Alcohol Abuse
☐ ☐	Allergies
☐ ☐	Anemia
☐ ☐	Angina Pectoris
☐ ☐	Arthritis
☐ ☐	Artificial Bones
☐ ☐	Artificial Heart Valve
☐ ☐	Asthma
☐ ☐	Blood Transfusion
☐ ☐	Cancer- Chemotherapy
☐ ☐	Colitis
☐ ☐	Congenital Heart Defect
☐ ☐	Cosmetic Surgery
☐ ☐	Diabetes
☐ ☐	Difficulty Breathing
☐ ☐	Drug Abuse
☐ ☐	Emphysema
☐ ☐	Epilepsy
☐ ☐	Fainting Spells
☐ ☐	Fever Blisters
☐ ☐	Frequent Headaches

Y N	Conditions
☐ ☐	Glaucoma
☐ ☐	Hay Fever
☐ ☐	Heart Attack
☐ ☐	Heart Surgery
☐ ☐	Hemophilia
☐ ☐	Hepatitis A
☐ ☐	Hepatitis B
☐ ☐	High Blood Pressure
☐ ☐	HIV+ AIDS
☐ ☐	Kidney Problems
☐ ☐	Liver Disease
☐ ☐	Low Blood Pressure
☐ ☐	Mitral Valve Prolapse
☐ ☐	Pace Maker
☐ ☐	Pneumocystitis
☐ ☐	Psychiatric Problems
☐ ☐	Radiation Therapy
☐ ☐	Rheumatic Fever
☐ ☐	Seizures
☐ ☐	Shingles
☐ ☐	Sickle Cell Disease
☐ ☐	Sinus Problems

Y N	Conditions
☐ ☐	Stroke
☐ ☐	Thyroid Problems
☐ ☐	Tuberculosis
☐ ☐	Ulcers
☐ ☐	Venereal Disease
☐ ☐	Yellow Jaundice

Y N	Allergies
☐ ☐	Aspirin
☐ ☐	Codeine
☐ ☐	Dental Anesthetics
☐ ☐	Erythromycin
☐ ☐	Jewelry
☐ ☐	Latex
☐ ☐	Metals
☐ ☐	Penicillin
☐ ☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

Brandon H. Barton, Jr., D.D.S., P.C. · 11200 E. McNichols · Detroit, MI 48234 · (313) 521-6400

FINANCIAL POLICY AND AGREEMENT

Thank you for choosing our office as your dental health care provider. We are committed to providing you with excellent dental care and convenient financial arrangements. We also believe it is in the best interest of everyone to establish definite financial arrangements. We accept cash, check, American Express, Master Card, Visa, Care Credit and Discover Cards.

PATIENTS WITH INSURANCE COVERAGE

- Please bring your insurance card and picture identification to your dental appointment.
- Deductibles, co-payments and any services not covered are to be paid in **full** at the time the service is provided.
- If your insurance company has not paid your account in full within 60 days, you will be billed for the remaining balance.
- If you have secondary insurance, we will submit your secondary insurance as a courtesy.

PATIENTS WITHOUT INSURANCE COVERAGE

If you do not have dental insurance coverage, payment is expected **in full** at the time of service.

SPECIALITY SERVICES

Payment in full will be required in advance for any sedation appointment. Procedures which involve laboratory work (crowns, bridges, dentures) will require a 50% payment when the impression is made, with the balance due when the prosthesis is inserted.

FINANCE CHARGE

Returned checks will incur a $35 fee. Balances older than 30 days will incur a monthly 1.0% finance charge which is 12% per year.

MISSED APPOINTMENTS

Our policy is to charge $50 for missed appointments unless cancelled at least 48 hours in advance. After two missed appointments, no other appointments will be provided.

MINOR PATIENTS

The adult accompanying a minor is responsible for full payment according to the guidelines described above.

COLLECTION FEES

If your account becomes 90 days over due, your account will be sent to collection. A collection fee of 40% is applied to the outstanding balance. Additionally, you may be responsible for any attorney fees and court costs.

PLEASE BE ADVISED

Professional services are rendered to our patients, not to an insurance company. It is important to remember that your dental insurance policy is an agreement **between you and your insurance company**. We are only a third party to this agreement. These insurance plans sometimes have changes in annual benefits and coverage from year to year. Consequently, we can only give you estimates of your co-pays. We submit most insurance forms on your behalf and will help you in any way we can to utilize your insurance benefits; however, you are ultimately responsible for any charges the insurance does not cover.

I have read the Financial Policy and I have been offered a copy. I understand and agree to abide by the terms outlined.

Signature: _____ Date: _____