Harris Dental

Brockton • W. Barnstable • Hyannis

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name ___________________________________Preferred name __________________

Birth date __________ SSN:__________________ If minor, parents' names _______________________

Home phone ________________ Cell phone ________________

Mailing address ____ City __________________ State____

Zip ________ Email address____

Employer____Occupation____________________________

Status: Married◯ Single◯ Child◯ Other◯ Gender: Male◯ Female◯

Referred by:____

BILLING, CREDIT, AND INSURANCE INFORMATION:No dental insurance? Ask about our Harris Dental Savings Plan

Subscriber name:__________________________________ Subscriber employer ___________________

Dental Insurance Co:____________________________________ ID# _______________________

Sub. DOB ________________Sub. SSN __________________ Relationship to Sub.______________________________

Secondary insurance? Yes or No

Subscriber name:__________________________________ Subscriber employer ___________________

Dental Insurance Co:____________________________________ ID# _______________________

Sub. DOB ________________Sub. SSN __________________ Relationship to Sub.______________________________

MEDICAL HEALTH HISTORY

Do you have/had any of the following conditions?

- ❏ Abnormal bleeding after extraction, surgery, or trauma AIDS/HIV+
- ❏ Alcoholism/drug use history
- ❏ Allergies or hives Explain:______________________________________
- ❏ Anemia or blood disorders
- ❏ Arthritis
- ❏ Artificial joint (Year of surgery:_____________)
- ❏ Asthma/COPD
- ❏ Blood transfusion
- ❏ Cancer/tumor Explain :__________________________
- ❏ Diabetes
- ❏ Emotional condition (ie. anxiety, depression, bipolar)
- ❏ Epilepsy, seizures, or fainting spells
- ❏ Hay Fever or sinus trouble
- ❏ Heart ailment or angina
- ❏ Heart murmur, mitral valve prolapse, heart defect
- ❏ Heart valve (Year of surgery:_____________)
- ❏ Herpes or cold sores
- ❏ High or low blood pressure
- ❏ Kidney disease
- ❏ Liver disease/Hepatitis
- ❏ Migraine headaches/frequent headaches
- ❏ Neurologic condition
- ❏ Pacemaker
- ❏ Rheumatic fever or rheumatic heart disease
- ❏ Smoke or use chewing tobacco
- ❏ Tuberculosis or other lung problems

Have you undergone any surgery or hospitalization?

Explain:____

Do you have any disease, condition, or problem not listed above?____

Allergic to, or have reacted to any of the following?

- ❏ Aspirin
- ❏ Codeine or other narcotics
- ❏ Latex materials
- ❏ Local anesthetics ("Novacaine")
- ❏ NSAIDS (Ibuprofen/Advil, Aleve)
- ❏ Penicillin
- ❏ Sulfa drugs
- ❏ Other: ____

**Please list the names of all medications you are taking*
____
____

Are you taking <u>any medications?</u>

- ❏ Antibiotics or sulfa drugs
- ❏ Anticoagulants (blood thinners)
- ❏ Antidepressants or tranquilizers
- ❏ Aspirin
- ❏ Cortisone or other steroids
- ❏ High blood pressure medication
- ❏ Insulin, Orinase, or other diabetes drugs
- ❏ Osteoporosis (bone density) medicine
- ❏ Nitroglycerin

Physician Name:_______________________________________
Office number:________________________

Are there any dental issues you would like to address? (ie. pain, sensitivity, esthetics, tooth crowding, etc.)
____

Women: Pregnant or Nursing ? Yes or No

Taking hormones or contraceptives/birth control pills?

Yes or No If yes, explain:__________________________

Consent for Services

We require that all payments or co-payments be made at the time of service.

For your convenience, we accept cash, checks, Mastercard, Visa, American Express, Discover, Care Credit, and in house financial options.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

As a gesture of courtesy, our office is happy to submit insurance claims for you. Remember that your insurance company is a contract between you,the insurance company and your employer; therefore, you are ultimately responsible for knowing the details of your insurance coverage. We will file your claim for no charge; however, we ask that deductibles and your estimated portion be paid as services are rendered. Although we gladly file dental insurance claims as a courtesy to you, all balances are ultimately your responsibility.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days unless previously written financial arrangements are satisfied.

After a balance is outstanding for 90 days, it will be turned over to a collection agency unless prior arrangements have been made.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient's examination. In consideration of the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five

(5) days of billing if credit is extended.

An appointment is an agreement between you and our office. If you must reschedule an appointment, please extend us the courtesy of 48 hours' notice, since changes in appointments affect other patients as well as our staff. If you cancel within 48 hours of the appointment, a broken appointment fee will be charged to your account. If the office has not received confirmation within 24 hours of your appointment the office will forfeit your appointment since no confirmation was made on your behalf.

- ❏ I have read the above conditions of treatment and payment and agree to their content.

Signature of patient (or parent): ____Date:______________