Steven K. Flick, D.M.D. **Today's Date _____**

PATIENT INFORMATION

Patient Name:_____Preferred:_____
Last First MI

Male / Female [] Married [] Single [] Child [] Other----------

Birth Date: _____ Social Security #:_____

Address: _____
City State Zip Code

E-mail: _____

Phone (Home)_____(Work:)_____(Cell/Pager)_____

Employer: _____Address _____

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

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Name:_____
Last First MI

Birth Date:_____ Social Security #:_____

Phone (Home) _____ (Work)_____(Cell/Pager)_____

Address: _____

_____
City State Zip Code

Employer:_____

EMERGENCY CONTACT – Not living with you

Name:_____ Phone: _____

Address: _____Relationship: _____

PRIMARY INSURANCE INFORMATION

Name of Insured:_____ ID #:_____

Insured's Home Address: _____

Insured's Birth Date: _____ Insurance Company: _____

Insurance Company Address:_____

Insured's Employer: _____Relationship to Patient: _____

SECONDARY INSURANCE COMPANY (If applicable)

Name of Insured:
_____ID#:_____

Insured's Home Address: _____

Insured's Birth Date: _____ Insurance Company: _____

Insurance Company Address: _____

Insured's Employer: _____Relationship to Patient: _____

Health Information

Have you ever had any of the following? Please check those that apply

☐ AIDS	☐ Excessive Bleeding	☐ Liver Disease	☐ Stomach problems
☐ Allergies	☐ Fainting	☐ Mitral Valve Prolapse *	☐ Stroke
☐ Anemia	☐ Glaucoma	☐ Mental Disorders	☐ Tuberculosis
☐ Arthritis	☐ Growths	☐ Nervous Disorders	☐ Ulcer
☐ Artificial Joints	☐ Hay Fever	☐ Pace Maker	☐ Codeine Allergy
☐ Asthma	☐ Head Injuries	☐ Are you pregnant?	☐ Penicillin Allergy
☐ Blood Disease	☐ Heart Murmur *	Due date _____	☐ Other: _____
☐ Cancer	☐ Hepatitis	☐ Radiation treatment	_____
☐ Diabetes	☐ High Blood Pressure	☐ Respiratory treatment	_____
☐ Dizziness	☐ Jaundice	☐ Rheumatism	
☐ Epilepsy	☐ Kidney Disease	☐ Sinus Problems	

***Have you ever been asked by your physician to pre-medicate before coming to an appointment? _____**

What medications are you currently taking? _____

Are you under the care of a physician? _____

If yes, please explain _____

Name of physician _____ Phone _____

Do you have any other health problems that need clarification or a specific dental problem you are concerned about?

_____ If yes, please explain _____

Have you ever had any complications with dental treatment? _____ If yes, please explain _____

_____

Date of last dental visit _____ Reason for visit _____

How often do you brush _____ Floss _____ Do your gums bleed? _____

THE RESPONSIBLE PARTY AGREES TO THE FOLLOWING:

- The information I have given is true and accurate to the best of my knowledge.
- I have been informed to contact this office if I choose not to receive correspondence or phone calls from Dr. Flick or his staff regarding upcoming dental care or necessary unscheduled dental treatment.
- **FAILED APPOINTMENTS (less than 48 hours notice) are a significant contributor to rising health care costs. Individuals who fail to show for an appointment may be assessed a fee of $25 per half hour.**

_____ _____

Signature of patient, parent or guardian Date

Patient's Name _____

Consent to Proceed:

I authorize Dr. Steven K. Flick and/or such associates as he may designate to perform those procedures as may be necessary or advisable to maintain my dental health. Including but not limited to nitrous oxide, general anesthesia and all those related to restorative, palliative, therapeutic, or surgical treatment. I understand that the administration of local anesthetic may cause an outward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation 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, preventative, and operative treatment procedures in hopes of obtaining the potential desired results, which may not be achieved for my benefit. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me and I have been given the opportunity to ask questions.
If the above named person is a minor or other ward to which I am responsible, the preceding is also understood.

HIPPA- Health Insurance Portability Accountability Act:

We will use your protected health information within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize coordination between hygienist, dental assistant, dentist, and office staff. We may share your information to collect payment for treatment you receive in our office. Your health information may be used during performance evaluations of our staff. We may be required to disclose to federal officials or military authorities health information necessary to complete an investigation related to public health or national security. We may notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. Because we believe regular care is very important to your oral and general health, it will be necessary to use your information to contact you regarding your treatment, including scheduling, follow-up care and reminder calls.

_____

Signature of Patient or Legal Guardian **Date**
(Parent, legal guardian or authorized agent of patient)

Financial Agreement

To Our Valued Patients:

In order to keep our fees as low as possible, we have implemented the following policies:

- **If the patient does not have dental insurance**, payment in full is expected on the day of service, unless other arrangements have been made.
- **If the patient does have dental insurance**, the responsible party will need to pay the patient portion and deductible on the day of service. The insurance will be billed as a courtesy, however, **please be aware if the insurance does not pay within 60 days from the date of service, payment in full is expected from the responsible party.**
- As the responsible party, I understand it is my responsibility to know and understand my insurance benefits. Fees quoted in this office are only estimates (we cannot guarantee what the insurance will pay) and may be subject to change. I will be personally responsible for anything the insurance does not cover.
- Upon examination the doctor will prepare a treatment plan. **The treatment plan is only an estimate** of the dental care and should not be construed as a statement of actual charges.
- There will be a $30 returned check fee assessed if applicable.
- Finance charges (18%) and/or late fees will be added to all past due accounts.
- The responsible party agrees to pay all attorney fees and court costs associated with collecting payment for services rendered. In case of default I also agree to pay up to 40% collection fee.

I have read and understand the above policies and agree to abide as outlined.

_____

Signature of patient or legal guardian **Date**