FLAT RATE DOCTORS

First Name:_____ MI:___ Last Name:_____

Birth Date: _____ SocSec:_____

Email:_____

Address:_____ City:_____ State_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Marital Status:_____ Spouse Name:_____

Who is responsible for the payment on this account?_____

Children Name and Birthday: Children Name and Birthday:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Emergency Contact: _____ Phone:_____

Relationship to Emergency Contact: _____

College Status: Full-Time or Part-Time School Name:_____

How did you find us? Google Search ☐ Website ☐ Facebook ☐ Hometown Values ☐ Event ☐

Other:_____

When was your last cleaning?_____

Do you have any dental concerns?_____

As a Courtesy to our patients we will file claims to your insurance; however it is the patient/guarantor's responsibility to keep us informed of new changes with insurance, If no information Is given you will automatically be responsible for all charges incurred at the date of your visit.

Policy Holder's Full Name:_____

Employer: _____ Policy Holder's Soc Sec: _____

DOB:_____ Ins. Company Name:_____

Address: _____ Customer Service Phone Number:_____

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FLATRATE DOCTORS

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body Health problems that you may have, or medication that you may be taking, could have an Important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No
If yes, please explain:_____
Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No
If yes, please explain:_____
Have you ever had a serious head or neck injury? ☐ Yes ☐ No
If yes, please explain:_____
Are you currently taking any medications, pills, or drugs? ☐ Yes ☐ No
If yes, please explain:_____
Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No
Are you on a special diet? ☐ Yes ☐ No
Do you use tobacco? ☐ Yes ☐ No
Women: ☐ Are you pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?
Do you use controlled substances? ☐ Yes ☐ No
Are you allergic to any of the following?
☐Aspirin ☐Penicillin ☐Metal ☐Codeine ☐Acrylic ☐Local Anesthetics ☐Latex ☐Other
If yes, please explain:_____
Do you, or have you had any of the following?

☐AIDS/HIV Positive
☐Alzheimer's Disease
☐Anaphylaxis
☐Anemia
☐Angina
☐Arthritis/Gout
☐Artificial Heart Valve
☐Artificial Joint
☐Asthma
☐Blood Disease
☐Blood Transfusion
☐Breathing Problems
☐Bruise Easily
☐Cancer
☐Chemotherapy
☐Chest Pains
☐Cold Sores/Fever Blisters
☐Congenital Heart Disorder
☐Convulsions
☐Cortisone Medicine
☐Diabetes
☐Drug Addiction
☐Easily Winded
☐Emphysema
☐Epilepsy or Seizures
☐Excessive Bleeding
☐Excessive Thirst
☐Fainting Spells/Dizziness
☐Frequent Cough
☐Frequent Diarrhea
☐Frequent Headaches
☐Genital Herpes
☐Glaucoma
☐Hay Fever
☐Heart Attack/Failure
☐Heart Murmur
☐Heart Pace Maker
☐Heart Trouble/Disease
☐Hemophilia
☐Hepatitis A
☐Hepatitis B or C
☐Herpes
☐High Blood Pressure
☐Hives or Rash
☐Hypoglycemia
☐Irregular Heartbeat
☐Kidney Problems
☐Leukemia
☐Liver Disease
☐Low Blood Pressure
☐Lung Disease
☐Mitral Valve Prolapse
☐Pain in Jaw Joints
☐Parathyroid Disease
☐Psychiatric Care
☐Radiation Treatment
☐Recent Weight Loss
☐Renal Dialysis
☐Rheumatic Fever
☐Rheumatism
☐Scarlet Fever
☐Shingles
☐Sickle Cell Disease
☐Sinus Trouble
☐Spina Bifida
☐Stomach/Intestinal Disease
☐Stroke
☐Swelling of Limbs
☐Thyroid Disease
☐Tonsillitis
☐Tuberculosis
☐Tumors or Growths
☐Ulcers
☐Venereal Disease
☐Yellow Jaundice
☐Othe

Have you ever had any serious illness not listed above?
If yes, please explain:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect 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.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN_____Date:_____

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FLATRATE DOCTORS

Financial Arrangements

We are committed to providing you with the best possible care. If you have dental or medical insurance we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered. We accept cash, check and all major credit cards. We also accept the Care Credit plan. We will be happy to process your insurance claim. Any such request must be accompanied by a completed insurance form and any updates each visit. Returned checks and balances older than 30 days will be subject to a $25.00 charge and additional collection fees. Charges may also be made for broken appointments and appointments cancelled without a 24 hour advance notice.

We will gladly discuss your proposed treatment and answer any questions relating your insurance. You must realize, however, that:

1.Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

2.Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage (such as 50% or 80%) of "U.C.R" is defined as usual, customary, and reasonable. This statement does not apply to companies that reimburse based on an arbitrary "schedule of fees", which bears no relationship to the current standard and cost of care in this area.

3.Not all services are a covered benefit in all contracts. Some insurance companies that reimburse base on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

4.You will be fully responsible for any balance not paid by insurance 60 days after your claim has been submitted. You will receive a bill from us showing the outstanding balance. We will be happy to provide any documentation to help assist you in collecting reimbursement from your insurance company directly. We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand and agree that I am responsible for any portion of my bill that my insurance company does not pay within 60 days of claim submission. I understand payment is due at the time of service. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18% APR) may be added to my account. I will be responsible for any and all charges applied by the collection agency if this account must be turned over to collections.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN_____Date:_____

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FLAT RATE DOCTORS

Insurance

I authorize release of information to all my insurance carriers.
I understand that I am responsible for any part of my bill not covered by my insurance.
I understand that I will be billed for treatment not paid by my insurance 60 days after claim submission.
I authorize payment directly to my doctor.
I authorize my doctor to act as my agent in helping me obtain payment from my insurance.

Consent for Services

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. Upon each diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required providing proper care.
I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

CONSENT TO PROCEED

I authorize the Doctors at Flat Rate Dental and/or such associates or assistants as she/he 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, including arrangement and/or administration of any sedatives (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 stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.
I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.
I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.
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.

Patient Name:_____

Signature: _____Date:_____

(Patient, legal guardian or authorized agent of patient)

Witness: _____Date:_____