PLEASANT DENTAL
DR. DAVID DAYNES D.D.S

PATIENT INFORMATION

PATIENT NAME:_____
HOME ADDRESS:_____
_____
HOME PHONE:_____
CELL PHONE:_____
E-MAIL:_____
DATE OF BIRTH:_____
SOCIAL SECURITY NO._____
EMPLOYER:_____
☐ MARRIED ☐ SINGLE ☐ MALE ☐ FEMALE

RESPONSIBLE PARTY

NAME:_____
ADDRESS:_____
_____
EMPLOYER:_____
WORK PHONE:_____
SPOUSE EMPLOYER:_____
SPOUSE WK PHONE:_____
RELATIONSHIP TO PATIENT:_____

Whom may we thank for inviting you to our office:_____
In case of emergency, please contact:_____
_____

Primary Dental Insurance

INSURED'S NAME:_____
INSURED'S SOC. SEC. #_____
INSURED'S DATE OF BIRTH:_____
INS. COMPANY NAME:_____
SECONDARY DENTAL INSURANCE ☐ YES ☐ NO

INS. COMPANY ADDRESS:_____
_____
SUB ID #:_____
GROUP #:_____
PHONE #:_____

Authorization and Office Policies

I authorize Dr. David Daynes to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor for which I have responsibility.

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, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval. I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated or swallowed. This unusual situation may require a series or 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 understand that as part of the dental treatment, including preventive procedures such cleaning and preventive procedures, including fillings of all types, teeth may remain sensitive after completion of treatment. Jaw muscles may be sore or tender with lengthy appointments. Gums and surrounding tissues may remain 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 during routine dental procedures. In some cases, sutures or additional treatment may be required. I do voluntarily assume any and all possible risks, if any, which may be associated with general preventive and operative treatment procedures in hopes to obtaining the potential desired results for my benefit or the benefit of my minor child. I acknowledge that the nature and purpose of foregoing procedures have been explained to me if necessary and I have been giving the opportunity to ask questions. I consent to the knowledge that additional work in addition to the treatment plan may be required in some cases (ie. deep cavities requiring root canal treatment or post-surgical complications ie. dry socket, etc).

I give my permission for any dental x-rays that Dr. Daynes recommends. I understand that all documents need to stay in the office but I can obtain a copy for a fee if needed. I agree that photographs of my teeth and surrounding tissues may be taken in order to submit to insurance for payment, research, and/or advertising purposes.

DENTAL INSURANCE: is a contract between a patient / guardian and the insurance company and in no way absolves the patient / guardians of full responsibility for the charges incurred with our office. Estimates of insurance payment made by this office are considered a guideline only. We can make no guarantee of the insurance payment(s) estimated.

SCHEDULED APPOINTMENTS: The time scheduled for your visit is set aside especially for you. We look forward to making your visit pleasant, comfortable and productive. In the unlikely event you are unable to make your appointment, we ask that you give us 24 hours notice so that we may give this time to other patients needing treatment. There will be a charge of $1.00/minute for appointment(s) missed or broken without 24 hours prior notice.

FINANCE CHARGES: a monthly charge of 1.5% (18% annually) will be added to all account balances not paid within 60 days of services. A late fee of $40/month will be assessed to all past due accounts. We want to stay in touch with you regarding your account and you authorize us or any company affiliated with us to contact you by phone, text, email, or mail which could result in charges to you by your telephone carrier.

PRIVACY AND CONFIDENTIALITY is important to us. I have reviewed and consent to the Notice of Privacy Practices document.

I have read, understand and agree to the above policies. In the event of default, I agree to pay all costs of collection (up to 50% of the amount owing) as well as court costs and reasonable attorney's fees in the event legal action is taken.

Signature:_____ Date:_____
(Patient or legal guardian)

Health History

1. Are you in Good Health? ☐ Yes ☐ No
2. Have there been any changes in you health within the past year? ☐ Yes ☐ No
3. Are you now under the care of a physician? ☐ Yes ☐ No
4. Name and phone number of physician_____
5. Have you had any serious illness, operation, or been hospitalized in the past 5 years? ☐ Yes ☐ No
6. Are you taking any medications, including non- prescription medications? Please list: ☐ Yes ☐ No

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7. Do you have or have you had any of the following diseases or problems?
   - Damaged heart valves or artificial heart valves, including heart murmur? ☐ Yes ☐ No
   - Cardiovascular disease (heart trouble, heart attack, angina, high blood pressure) ☐ Yes ☐ No
   - Do you have inborn heart defect? ☐ Yes ☐ No
   - Do you have a pace maker? ☐ Yes ☐ No

• Allergies	☐ Yes	☐ No	• Stomach ulcer or hyperacidity	☐ Yes	☐ No
• Sinus Trouble	☐ Yes	☐ No	• Kidney Trouble	☐ Yes	☐ No
• Asthma	☐ Yes	☐ No	• Tuberculosis	☐ Yes	☐ No
• Fainting Spells or seizures	☐ Yes	☐ No	• Persistent or bloody cough	☐ Yes	☐ No
• Hepatitis, jaundice, liver disease	☐ Yes	☐ No	• Persistent swollen glands	☐ Yes	☐ No
• AIDS or HIV infection	☐ Yes	☐ No	• Low blood pressure	☐ Yes	☐ No
• Thyroid problem	☐ Yes	☐ No	• Sexually transmitted disease	☐ Yes	☐ No
• Respiratory Problems	☐ Yes	☐ No	• Epilepsy, neurological disease	☐ Yes	☐ No
• Arthritis or painful joints	☐ Yes	☐ No	• Problems with mental health	☐ Yes	☐ No
• Persistent weight loss	☐ Yes	☐ No	• Cancer	☐ Yes	☐ No
• Diabetes	☐ Yes	☐ No	• Immune system problems	☐ Yes	☐ No
• Abnormal bleeding	☐ Yes	☐ No	• Blood transfusion	☐ Yes	☐ No
• Anemia	☐ Yes	☐ No	• Tumor or growth	☐ Yes	☐ No

8. Are you allergic or have you had a reaction to:
   ☐ Local anesthetics ☐ Penicillin or other antibiotics ☐ Sulfa Drugs ☐ Barbiturates or sedatives
   ☐ Aspirin ☐ Iodine ☐ Codeine or narcotics ☐ Other_____
9. Do you have any disease, condition, or problem not listed above that we should know about? ☐ Yes ☐ No

_____

10. Have you ever had serious trouble associated with previous dental treatment?_____
11. Are you wearing removable dental appliances? ☐ Yes ☐ No
12. Have you ever used tobacco of any type? ☐ Yes ☐ No
13. Do you use alcoholic beverages? ☐ Yes ☐ No

Women:

14. Are you pregnant? ☐ Yes ☐ No
15. Are you nursing? ☐ Yes ☐ No
16. Are you taking birth control pills? ☐ Yes ☐ No

I certify that I have read and understand the above. I acknowledge that my questions, if any, have been answered. I will not hold Dr. Daynes or his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient or Guardian: _____ Date_____

Signature of Dentist or Hyg. _____Date_____

Health history updates: _____ _____ _____

Pleasant Dental's Financial Policy

Understanding our patient financial agreement is as important as the services we render. It is our responsibility to inform you of your charges and our payment policy prior to service. **Payments are expected at the time services are rendered.** We accept cash, checks, and all major credit cards. We will estimate insurance copays to the best of our abilities and ask these to be paid at time of service. Patients with insurance who would like a more exact estimate of expected insurance coverage can request us to submit a pre-authorization to the insurance company (this will take 6-8 wks+ for processing).
Would you like work pre-authorized? ☐ Yes ☐ No

Our options are . . .

1. A 3% savings for payments in **Full** by **Cash or Check** at time of service. We can offer this because it reduces the cost to our office in billing and staffing hours and therefore we want to share that savings with you, our valued patient. Credit card companies charge us a high percentage rate and therefore we are not able to extend this courtesty to those wishing to use their credit cards.

2. *Insured patients only:* Payment of estimated co-payment at time of service.

3. Major Service TWO Payment Option: We offer a two-payment option for Crown, Bridge, and Denture treatment. We ask that you pay one-half of the fee at the first appointment and the second half at the seat date appointment. The negative here is **NO Discount**.

4. In-office Financing – over $500:

Up to 3 month interest free credit/bank card monthly debit with signed agreement. 25% down before treatment is started, $5 a month transaction fee. In the event that the payment doesn't go through, a **$40/mo monthly no-payment charge** will be assessed. We are unable to carry accounts past 3 months.

5. For those times when the first four just don't make it . . we have another great option – CareCredit. No-interest and long term options, ask for an application.

We will gladly accept personal checks under the following guidelines: 1. There will be a $25 fee assessed for returned / bounced checks. 2. We are unable to accept post-dated checks. A finance charge of 1.5% per month (annual rate of 18%) will be assessed on any unpaid balance after 60 days.

Broken appointments: This time that has been reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hours notice. There will be a $40 broken appointment charge for cancelled or no-showed appointments without 24 hour notice.

_____ _____ _____

Option # Patient Signature Date