PLEASANT DENTAL
DR. DAVID DAYNES D.D.S — Both Sides

PATIENT INFORMATION

PATIENT NAME:________________________
HOME ADDRESS:_______________________
____
HOME PHONE:_________________________
CELL PHONE:__________________________
E-MAIL:_______________________________
DATE OF BIRTH:________________________
SOCIAL SECURITY NO.__________________
☐ 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:____________
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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 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 advertizing purposes.

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.

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 $10/month will be assessed to all past due accounts.

Your 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

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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 co pays to the best of our abilities and ask these to be paid at time of service. Estimates of insurance payment made by this office are considered a guideline only. We can make no guarantee of the insurance payment(s) estimated. 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 courtesy 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:
   a. Up to 6 month interest free credit card monthly debit with signed agreement. 25% down before treatment is started, $5 a month transaction fee.

5. For those times when the first four just don't make it . . we have another great option – Capital One Healthcare Financing. Up to a 60 month loan, 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. A late fee of $10/month will be assessed to all past due accounts

Broken appointments: Your appointment time 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 $1/minute broken appointment charge for cancelled or no-showed appointments without 24 hour notice.

__________ ____________________________ ________

Option # Patient Signature Date