Timm Family Dentistry

****PLEASE GIVE ANY NEW INSURANCE INFORMATION TO FRONT DESK*****

Please list on back if more room needed

Patient name: _____DOB: _____ Social Security #: _____

Mailing Address: _____

Cell/Home Phone #_____Email: _____

Emergency Contact & Phone #: _____

Do you have a current physician? If so, who? _____

Have there been any changes to your health since your last dental visit? **YES or NO**

If yes, Please list: _____

_____

DENTAL/MEDICAL HISTORY

Current Medical / Dental issues? _____

Current Medication? _____

Have you ever taken BISPHOSPHONATES? (Boniva, Fosamax, Prolia) _____

Are you pregnant? Y / N

Do you use cigars, cigarettes, pipe, or chewing tobacco? (please circle)

PLEASE CIRCLE ANY OF THE FOLLOWING YOU HAVE HAD, OR NOW HAVE:

Alzheimer's

AIDS/HIV	Diabetes	Mitral Valve Prolapse
HPV	Eating Disorder	Nervous Problems
Acid Reflux	Epilepsy	Pacemaker/Heart Surgery
Anaphylaxis	Fainting	Psychiatric Care
Arthritis	Food Allergies	Rapid Weight Loss/Gain
Artificial Heart Valves	Glaucoma	Radiation Treatment
Artificial joints	Heart Murmur	Respiratory Disease
Asthma	Heart Problems	Rheumatic Fever/Scarlet Fever
Anemia	Hemophilia	Shingles
Atopic (allergy prone)	Herpes	Shortness of Breath
Osteoporosis	Hepatitis	Skin Rash
Blood Disease	Hip or Knee Replacement	Spina Bifida
Cholesterol	High Blood Pressure	Stroke
Cancer	Jaw pain	Surgical Implant
Chemical Dependency	Kidney Disease	Swelling (feet/ankles)
Cortisone Treatments	Liver Disease	Thyroid Disease
Cough (persistent)	Material Allergies	Tobacco Habit
Cough Up Blood	Tuberculosis	Ulcer/Colitis
Sleep Apnea	Seizures	

Other_____

ARE YOU ALLERGIC / HAVE YOU REACTED TO ANY OF THE FOLLOWING:

Aspirin Penicillin Codeine Latex Dairy Sulfa Anesthetic

Other_____

Patient Signature_____Date_____

Reviewed by Doctor_____ Date _____

Acknowledgement of receipt of notice of privacy practices

Timm Family Dentistry

You may refuse to sign this acknowledgement

I have reviewed the office's Notice of Privacy Practices.

Please list any persons you authorize our office to release information to: (i.e. spouse, children, parents)

Name:	Relationship:
_____	_____
_____	_____
_____	_____

Patient name: _____
Signature: _____
Date: _____

Financial Agreement and Office Policy

We are committed to providing you with the highest quality of care. Our fees are a reflection of the quality of care we provide. We continue our commitment by offering a variety of financial options to enable you to receive the dental care you need. We accept cash, check, VISA, MasterCard, Discover and American Express, and HSA cards.

We have also partnered with a third-party company, Care Credit, to offer the flexibility of deferred interest and extended payment options.

For our patients without insurance, we offer a 5% discount with payment in the form of cash or check.

We will communicate all recommended treatment options and associated fees, prior to the start of treatment. Payment is expected at the time of treatment. A delinquent account impedes our ability to provide you with the quality dental care that you deserve. It is our policy that the parent or guardian who accompanies a child to our office for treatment is responsible for payment of all services rendered.

If you have dental insurance, as a courtesy to you, we will submit your insurance claim electronically for processing. We can give you a financial ***estimate*** or submit a predetermination to insurance. An authorization is not a guarantee of payment. Please refer to your carrier handbook for specifics on benefit coverage for your plan. Costs not covered by your insurance carrier becomes the immediate responsibility of the guarantor.

Appointment scheduling is a critical part of our day. With that in mind, we require at least a two working day notice to cancel or move a scheduled appointment. We make every effort to provide appointment reminders for our patients so that they are informed of the next appointment they have scheduled. **If an appointment is cancelled with less than 48 hours' notice, we will charge your account $50 for a missed appointment.**

Timm Family Dentistry is NOT responsible for the collection of dental insurance benefits but that claims will be sent as a courtesy to the patient. We make every attempt to ensure the accuracy of your dental claim based on the information provided by each patient. It is the patient's responsibility to update carrier information, as changes become necessary. You understand that all costs not paid by your insurance carrier are the responsibility of the guarantor and due within 90 days. Unless a payment plan has been agreed upon, a finance charge of 1.5% per month or 18% per year will be added to all accounts over 60 days regardless of insurance coverage. I agree to pay that finance charge.

By signing this agreement you understand and agree to the policies of this office. Furthermore, you understand that we do our best to estimate treatment and its cost. In the event that legal or collection action becomes necessary, I further agree to pay ALL legal collections and/or court costs involved.

Date: _____

Signature: _____