

PATIENT INFORMATION

Patient Name: Last _____ First _____ MI _____ Preferred _____

Gender: Male Female Family Status: Married Single Child Other _____

Social Security #: _____ Birth Date: _____ Driver's License# _____

Phone Numbers: Home: _____ Work: _____ Ext: _____

*Cellular: _____ *E-mail: _____

*Our office uses e-mail and text messaging to inform you of appointment confirmation, changes or availability and monthly specials.

Address: _____

Street

Apartment #

City

State

Zip Code

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

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Premed Needed |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Rheumatism | Currently taking any Medications?
Yes
No |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Murmur / MVP | <input type="checkbox"/> Stomach Problems | Please list below:

_____ |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Tumors | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Ulcers | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Venereal Disease | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Mental Disorders | ALLERGIES | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Codeine Allergy | |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Penicillin Allergy | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Sulfa Allergy | |
| <input type="checkbox"/> Glaucoma | Due Date: _____ | <input type="checkbox"/> Egg Allergy | |
| <input type="checkbox"/> Growths | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Latex Allergy | |
| | <input type="checkbox"/> Respiratory Problems | | |

Have you ever been diagnosed with or taken medication for osteoporosis? _____

Do you smoke? _____ If yes, how much? _____

Do you drink alcohol? _____ If yes, how much? _____

Do you do recreational drugs? _____ If yes, what kind and how much? _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian

Date

INSURED OR RESPONSIBLE PARTY INFORMATION

The following is for: yourself the patient's spouse the person responsible for payment the insured

Name: _____

Male Female

Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ Work: _____ Ext: _____ Cellular _____

Address: _____

Street

Apartment #

City

State

Zip Code

INSURANCE INFORMATION (PRIMARY)

Insurance Plan Carrier: _____ ID #: _____ Group #: _____

Name of Insured: Last _____ First _____ MI _____ Insured's Birth Date: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: Self Spouse Child Other _____

INSURANCE INFORMATION (SECONDARY)

Insurance Plan Name and Address: _____

Name of Insured: _____ First _____ MI _____ Insured's Birth Date: _____

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: Self Spouse Child Other _____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative

Dental Office Yellow Pages Newspaper School Work Other _____

Name of person or office referring you to our practice _____

EMPLOYMENT INFORMATION

The following is for: The patient The patient's spouse The person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code Phone

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian/ guarantor of payment/responsible party

I give permission to release any protected information to the following people: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT (HIPAA), 1996

<http://www.hhs.gov/ocr/hipaa/finalreg.html>

Print Name

I _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY

Higginbotham Family Dental

2200 West Kingshighway | Paragould, AR 72450 | (870) 215-0058

WRITTEN FINANCIAL POLICY

Thank you for choosing Higginbotham Family Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, Mastercard, or Discover Card

We offer a 5% discount to patients who do not have dental insurance and pay for their treatment in full with cash/check prior to completion of care for procedures over \$300.

- NO INTEREST¹ Payment Plans² from CareCredit and Chase Health Advantage

1. Allow you to pay over time with NO INTEREST¹
2. Convenient, low monthly payment plans² also available
3. No annual fees or pre-payment penalties

Please note:

Higginbotham Family Dental requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For plans requiring multiple appointments, alternative payment arrangements may be provided.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.³ **However, the patient understands that the insurance is an agreement between the insured and the insurance company, not the insurance company and Higginbotham Family Dental.** The patient also understands that they are responsible for their balance regardless of their insurance.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)

Fee estimates are only valid for 90 days and are subject to change.

¹If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

²Subject to credit approval

³However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.