Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T

Address: _____
Street Apartment #

_____

E-mail: _____

Do you have dental insurance to be filed? ☐ **Yes** ☐ **No**

Health Information

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Bisphosphonates, Oral or IV
- ☐ Blood Disease
- ☐ Breathing Problems
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drugs (recreational)
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Problems
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Organ Transplant
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ **Pregnancy**
  Due Date _____
- ☐ Radiation treatment
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Snoring
- ☐ Steroids taken in last 2 years
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Surgery
- ☐ Tobacco use
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Sulfur Allergy
- ☐ Latex Allergy
- ☐ Other Medication Allergy:
  _____
  _____
  _____
- ☐ Other Allergies?
  _____
  _____

PLEASE LIST ALL MEDICATION(s):

_____

_____

_____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

Referral Information

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

☐ Dental Office ☐ Yellow Pages ☐ Online Search ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Dental Appointment Agreement

Welcome to Paris Family Dental! We are so very excited that you have chosen to be a part of our family!

As a part of our family, here are a few things you can expect from us:

1. As a patient here, you can expect to be treated as a member of our family. We will do everything we can to make you feel comfortable and welcome and we ask that you please let us know if this is not the case.
2. Paris Family Dental promises to use cutting edge techniques and technology and the same materials we would use in our mouths. Our practice has evolved from regular dentistry to include services such as invisalign, implants and bone grafting, sinus lifts and much more.
3. At Paris Family Dental we stand behind our work and will continue to provide you with quality work at an affordable price.
4. Dr. Del Toro is available to you after hours to address any concerns or answer any questions you may have. As an active patient, you will be given Dr. Del Toro's after hours emergency number (located on each appointment card).

Here is *ONE* thing we expect from you:

1. When you make an appointment you *actually* keep it **on time**. Now, we know situations arise, but if something comes up, please give us the courtesy of a letting us know **48 hours** in advance if you cannot keep your appointment. Broken appointments result in lost time that could have been used to treat other patients.

The following are some further details you will need to know as part of our family:

Rescheduling Appointments

The dental staff understand that sometimes situations arise that require rescheduling of your appointment. If you need to reschedule, please call our office as soon as you know that you will not be able to keep the appointment, at least **48 hours** before the appointment time. Our office will call, text, and/or email to confirm you will be at your appointment. Appointments that are NOT confirmed within **48 hours** of appointed time are subject to rescheduling ***without*** notification.

Initials:_____ _____

Broken Appointments

If you miss a scheduled appointment or cancel with less than 48 hours notice, a broken appointment will be recorded in your dental chart. If you are ***more than ten minutes late for an appointment***, a broken appointment will also be recorded, and you may have to be rescheduled if there is not enough time to complete your procedure. It is not fair to keep other patients waiting because you arrived late.

If you have two broken appointments during a six month period, you will only be rescheduled by prepaying for each of your future appointments via a **NON-REFUNDABLE** rescheduling fee equal to that of the treatment cost to be provided at that next scheduled appointment. This fee will be applied to treatment costs only if you present and keep the pre-paid appointment. If you do not present and keep your pre-paid appointment, or if you cancel/reschedule with ***less than***

48 hours notice, the rescheduling fee that was paid prior to scheduling your appointment will be forfeited by you and NOT returned to you. Additionally, appointments may still be scheduled without paying the re-scheduling fee but only on a "walk-in" or "ASAP list" basis until Paris Family Dental believes consistency with keeping scheduled appointments has been established.

Initials:_____ _____

Scheduling Two-hour Appointments

Sometimes appointment lengths are scheduled for two or more hours, either at the request of the patient or because the procedure(s) necessitates a longer working time. Such appointments require a **NON-REFUNDABLE** scheduling fee equal to half the amount of the treatment cost to be provided at that next scheduled appointment. This fee will be applied to treatment costs only if you present and keep the pre-paid appointment. If you do not present and keep your pre-paid appointment, or if you cancel/reschedule with ***less than 48 hours*** notice, then the scheduling fee that was paid prior to scheduling your appointment will be forfeited by you and NOT returned to you.

Initials:_____ _____

State law reserves the right for Dr. Brandon Del Toro to dismiss any patient from his dental practice without reason. If you are dismissed as a patient, however, you will be eligible for emergency dental care for thirty days only, after the date of dismissal.

I have read, understand and agree to all of the above and 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.

_____ _____

Patient Name (Please Print) Date

_____

Patient or Guardian Signature

_____ _____

Witness Date

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 at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished can be charged directly to the patient and that he or she is personally responsible for payment of all dental services on the day services are rendered. This dental office cannot render services on the assumption that our charges will be paid by an insurance company. This office will help prepare the patient's primary insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. If we have not received payment, cannot confirm our sent claim was received, and/or have not received a response, electronic or via mail, from patients' insurance, or otherwise, from 45 days from our submission, we will then deem the patient's outstanding balance to be due and payable by the patient. We will continue to make an honest effort to receive payment from the insurance. Additionally, we *do not* estimate, nor base a patient's estimated portion on secondary insurance, only on primary insurance, however we will submit claims to the secondary insurance.

A finance charge of **18% per month** on the unpaid balance will be charged on all accounts exceeding 60 days. Unpaid balances beyond 60 days will accrue interest at the rate listed above. Patients with insurance will begin to accrue interest 30 days after all effort to receive PRIMARY insurance monies is deemed complete. ACCOUNTS OVER 90 DAYS WILL BE SENT TO COLLECTIONS. In the event any balance is not paid at time account is sent to collections, the undersigned agrees to pay a collection fee equal to 40% of the unpaid balance. In the event of a lawsuit to collect an unpaid balance and associated fees, the undersigned further agrees to pay court cost and attorney fees. If a payment plan is agreed upon by the undersigned and the doctor, the balance will continue to accrue interest at the rate above until the balance is paid in full. All statements will accrue a $3.00 statement fee and all certified mail communication will accrue a $25.00 processing and postage fee.

Initials:_____ _____

I understand that the fee estimate listed for this dental care can only be extended for a period of six months 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 use any known contact information and method to discuss matters related to this form, including but not limited to, collection of a debt.

Patient Name (Please Print) Date

Patient or Guardian Signature

Witness Date