Patient Information

Patient's Name: _____
last first middle likes to be called

Date of Birth: _____ Age: _____ Sex: _____ Soc. Sec. #: _____

Phone (Cell): _____ (Work): _____

Address: _____
street city state zip

Referred By: _____

Names & Ages of Children in Family: _____

Father's Name: _____ Employment: _____ Work Phone: _____

Mother's Name: _____ Employment: _____ Work Phone: _____

Responsible Party Information

Person Responsible for Account _____
last first middle

Relationship to Patient: _____ Date of Birth: _____ Soc. Sec. #: _____

Address (if different from patient) _____
street city state zip

Phone: _____ Cell /Alt Phone: _____ Email: _____

Person Responsible Employed by: _____ Business Phone: _____

Insurance Information

Primary Name of Insured: _____ Is insured a patient ☐ Yes ☐ No
Last first middle

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

Insured Birth Date: _____ SS #: _____

Address (If different from patient): _____
Street city state zip

Contact #: _____

Insured Employer Name: _____

Business Address: _____
Street city state zip

Dental Insurance Company: _____ Subscriber #: _____ Group #: _____

Address: _____ Contact #: _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

How often does your child brush: _____ floss: _____

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

- ☐ ADD/ADHD
- ☐ Autism
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Other Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Fainting
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pregnancy
  Due Date: _____
- ☐ Premature Birth
  # weeks: _____
- ☐ Radiation Treatment
  Completed: _____
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Smoking/Tobacco Use
- ☐ Recreational Drugs
- ☐ Other: _____

- Have you ever had any complications following dental treatments? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you had any surgeries? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you currently taking any medications? ☐ 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: _____

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.

_____ Date: _____

Signature of patient, parent or guardian

FINANCIAL OFFICE POLICY

In consideration for the professional services rendered to me, I agree to pay for these services, at the time the services are rendered unless financial arrangements are made in advance. All emergency dental services, or any fees reflect our commitment to the quality of care that our patients deserve. If you have insurance, we are happy to assist you in processing your insurance claims to maximize your benefits. INSURANCE ESTIMATES will assist you in determining your APPROXIMATE OUT OF POCKET EXPENSE. Please note THAT INSURANCE ESTIMATES ARE NOT A GUARANTEE OF PAYMENT FROM YOUR INSURANCE COMPANY. We ask you to keep in mind that your insurance company is a contract between your employer, yourself and the insurance company. We are not part of that agreement.
REGARDLESS OF INSURANCE COVERAGE, ALL FEES AND ACCOUNT BALANCES ARE THE PATIENTS RESPONSIBILITY.

As a patient of Victoria PDO I understand my financial responsibility and also give consent to use this signature on all insurance claims, to release records, including X-rays for insurance purposes only. I also give you permission to contact me by phone or e-mail concerning any matters related to my treatment or account. I give consent for my dental treatment as deemed necessary. Thank you for choosing Victoria PDO.

HIPAA

ACKNOWLEDGEMENT OF RECEIPT/REVIEW OF NOTICE OF PRIVACY PRACTICES
I have received/reviewed a copy of this office Notices of Privacy Practices.

**** IT IS YOUR LEGAL OPTION TO NOT SIGN THIS ACKNOWLEDGEMENT; HOWEVER, OUR POLICY STATES THAT IF WE DO NOT HAVE THIS SIGNED ACKNOWLEDGEMEMT FROM YOU, WE WILL NOT BE ABLE TO PROVIDE YOU WITH OUR SERVICES.****

_____ Date:_____Relationship to Patient:_____
Signature of patient, parent or guardian

_____ Date:_____Relationship to Patient:_____
Signature of guarantor of payment/Responsible Party

- **IF YOU WOULD LIKE A COPY OF THIS PAGE, PLEASE NOTIFY THE FRONT DESK.**

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

- o Communication barriers prohibited obtaining acknowledgment
- o An emergency situation prevented us from obtaining acknowledgement
- o Other

If other, was marked, please specify:

Name of office personnel: _____