INSURANCE INFORMATION

The following information is requested of the <u>PRIMARY</u> insurance holder:

Name of Primary Insured: _____
Last First (Preferred)

Sex (please circle): Male Female Relationship to patient (please circle): Spouse Child Other

Social Security #: _____ Date of Birth: _____

Insurance Carrier: _____ Employer: _____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice?

Friend	School	Newspaper
Relative	Work	Yellow Pages
Another Dental Office	Magazine	Online

Name: _____

CONSENT FOR SERVICES

As a condition of your treatment by this office, payment is expected when services are rendered. Financial responsibility on the part of each patient will be determined prior to receiving treatment or other services; however, your financial responsibility may change in the event of a dental emergency or in the event that Dr. Cooper deems necessary changes to treatment during your appointment (i.e. additional surfaces, necessary changes in procedures, etc.).

All emergency dental services, or any dental services performed without previous financial arrangements, as stated above, must be paid IN FULL at the time services are rendered. **Personal checks WILL NOT be accepted as a form of payment for emergency services.**

Patients who carry dental insurance understand that **all dental services rendered are charged directly to the patient, or responsible party, and that he or she is personally responsible for all charges incurred.** Our office will prepare your insurance claims and apply insurance payments directly to your account. In the event that any claim is denied, **for any reason**, our office will *assist* you in making collections from your insurance carrier; however, our office cannot render services on the assumption that your charges will be paid by your insurance carrier.

An interest rate of 18% will be charged to your account monthly on any unpaid balance(s) exceeding more than thirty (30) days, unless previously written financial arrangements are satisfied. An account that goes unpaid for more than sixty (60) days will be regarded as a matter for collections. If your account advances to collections, you are financially responsible for all costs that may incur in collecting on said account (i.e. attorney fees, filing fees, court costs, etc.).

I understand that the treatment fee estimate for my dental care can only be extended for a period of six (6) months from the date of the patient examination.

At the time services are rendered to me, I agree to pay the fee(s) of all said services to Grayhawk Dental Associates (Dr. Mitchell Cooper). I further agree that the fee(s) of said services shall be billed unless objected to, by me in writing, within the time for payment thereof.

By signing this form, I hereby consent Grayhawk Dental Associates (Dr. Mitchell Cooper) to provide dental services to me, or the patient whom I am responsible for, listed on the first page of this form. I grant my permission to Grayhawk Dental Associates' staff to telephone or email me at any of the telephone numbers and/or email addresses provided to discuss matters related to this form.

_____ _____
Signatures of patient, parent or guardian Date

PATIENT INFORMATION

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

Sex (please circle): Male Female Family Status (please circle): Married Single Child Other

Social Security #: _____ Date of Birth: _____

Phone (home): _____ (Cell): _____

(work): _____ (Other): _____

Address: _____
Street Apartment/Suite/Unit #

_____
City State Zip Code

Email: _____@_____
Please PRINT legibly. We use emails to confirm appointments and other office-patient correspondence.

HEALTH HISTORY

Do you currently or have you ever had any of the following? Please check all that apply:

AIDS/HIV
Allergies (please list):
_____
_____
Arthritis
Artificial Joints:
_____
_____
Asthma
Blood Disease
Cancer (please list):
_____
_____
Diabetes
Dizziness

Excessive Bleeding
Fainting
Glaucoma
Head Injuries
Heart Attack
Heart Disease
Heart Murmur
Hay Fever
Hepatitis
High Blood Pressure
Jaundice
Kidney Disease
Liver Disease
Mental Disorders:
_____
_____

Nervous Disorders
Radiation Treatment
Respiratory Problems
Rheumatism
Sinus Problems
Stomach Problems
Stroke
Tuberculosis
Tumors
Ulcers
Venereal Disease
Other (please list):
_____
_____
_____

PRE-MEDICATION REQUIRED:
_____

PLEASE CHECK IF NONE OF THE PRECEDING HEALTH CONDITIONS APPLY – Initial here: _____

Do you have any health problems that need further clarification?

_____

_____

Are you currently under the care of a physician? If yes, please explain:

_____

_____

Name of Physician: _____ Phone: _____

City, State: _____

To the best of my knowledge, all of the preceding information provided is true and correct. If I experience any changes in my health, I promise to inform Dr. Cooper and his staff at my next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian