WELCOME TO DR. ARTZER'S OFFICE

Home Number _____

Work Number _____

Cell Number _____

_____

Last Name First Name Initial Preferred Name

Street Address _____ City _____ State _____ Zip _____

Social Security # _____ Birthdate _____ ( ) Single ( ) Married ( ) Separated

Sex ( ) Male ( ) Female Age _____ Whom may we thank for referring you? _____

What was the reason for leaving your last dentist? _____

Date of last dental visit _____ Date of last dental x-rays _____

Do you like your smile? _____ If no, why not? _____

Employer _____ Occupation _____

Spouse/Parent Name _____ Spouse/Parent Birthdate _____

Employer _____ Occupation _____

Spouse/Parent Social Security # _____

Who is responsible for this account? _____ Relationship to patient _____

Name of Dental Insurance Company _____ Group Number _____

In case of emergency, who should be notified? _____ Phone _____

Have you ever had any of the following: (Check all that apply)

( ) Aids
( ) Allergies to Anesthetic
( ) Allergies to Medicine
( ) Arthritis
( ) Artificial Valves or Joints
( ) Asthma
( ) Back Problems
( ) Blood Disease
( ) Cancer
( ) Chemical Dependency
( ) Chronic Diarrhea
( ) Circulatory Problems
( ) Diabetes
( ) Epilepsy
( ) General Allergies
( ) Headaches
( ) Heart Problems
( ) Hemophilia
( ) Hepatitis / Jaundice
( ) High Blood Pressure
( ) Jaw Pain
( ) Low Blood Pressure
( ) Mitro Valve Prolapse
( ) Nervous Problems
( ) Psychiatric Care
( ) Radiation Treatment
( ) Recent Unexplained Weight Loss
( ) Respiratory Disease
( ) Rheumatic Fever
( ) Sinus Problems
( ) Special Diet
( ) Stroke
( ) Swollen Neck Glands
( ) Ulcer / Liver Disease
( ) Venereal Disease

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____

If so, what? _____ Have you ever responded adversely to medical or dental treatment? _____

Are you taking medication at this time? _____ If so what? _____

Are you under the care of a physician? _____ If so, why? _____

(Women) Do you suspect that you are pregnant? ( ) Yes ( ) No

If patient is a child, what is his / her weight? _____

Is there anything else we should know about your medical history? _____

This above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits for which I am entitled. I will not hold Dr. Artzer or any staff member responsible for any errors or omissions that I may have made in the completion of this form. I understand a $50 fee will be applied to my account for any broken appointments without a 24-hour notice.

Date _____ Signature _____

FINANCIAL AGREEMENT

I agree that I am ultimately responsible for my account balance for services rendered. I certify that the above information is true and correct to the best of my knowledge. In the event that my account has to be referred for collection, there will be a 40% collection fee added to my account balance. I agree that I am responsible for all collection and attorney fees. I am responsible for all court costs.

Date _____ Signature _____

MINOR / CHILD CONSENT

I, being the parent or guardian of _____ do hereby request and authorize the dental staff to perform necessary dental services for my child, including, but not limited to x-rays and administrations of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Date _____ Signature _____

ALERT

CLINICAL RECORD

CARD No. _____

DATE	TOOTH	SERVICES RENDERED	FEES	

Dr. Artzer and Your Insurance Plan - How They Work Together

The staff at Dr. Artzer's office is pleased that you have insurance benefits to help with the cost of your dental care. We would like to help you obtain the maximum use of these benefits. With this in mind, please read the information on our claims process so that we can work together to ensure this benefit.

Do you accept my insurance? How much will they pay?
We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for services). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payments by a given company, they do change, therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. If you would like to know your exact insurance benefits, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. This does delay treatment but will give you the exact out of pocket figures you may require.

I thought I paid my portion but I got a bill, why?
We base the patient portion of your bill on our most current data but there are many factors that can affect the estimate. There may be a deductible (individual or family) or you may have received treatment in another office prior to joining Dr. Artzer's office which is not calculated into our database. Sometimes you need to see a specialist for care, which also uses your annual benefits. Insurance companies do not (and cannot in most cases) notify us of changes to your benefits, they only notify you. If these situations apply to you, please let us know when we estimate your treatment plan so we may adjust accordingly.

Insurance didn't pay, now what?
We bill your insurance as a courtesy. If insurance does not pay within 90 days, Dr. Artzer reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. It is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

Financial Options
Dr. Artzer does request payment in full for your portion at the time of service. We accept MasterCard and Visa. If you are in need of an extended finance option, we also work with Capital One Finance, and interest bearing revolving charge designed to meet your treatment plan needs.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitment that I may incur as a result of treatment at Dr. Artzer's office.

_____ _____

Signature Date

I assign Dr. Mark Artzer all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release my information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions whether manual or electronic.

_____ _____

Signature Date

NAME_____ DATE_____

DATE OF BIRTH_____

I give permission to receive text messages at this number_____

I give permission to receive email at this address _____
I give permission to call my work_____

I give permission to leave information on my cell and or home numbers
Pertaining to any of my dental information

Cell_____ Work_____

Home_____

Any of my dental information can be given to _____

Any Phone Correspondence HOME WORK CELL

SIGNATURE_____

DATE_____

Any Specific Request

_____

_____

_____

Total Health Checklist

This information will assist the dental professionals in assessing both your oral health and its impact on your overall health. Please answer completely to the best of your knowledge.

Total Health
BEYOND THE MOUTH

Patient Name *(Last Name, First Name)* _____

Height_____ Weight_____

How frequently have you been brushing your teeth? _____

How frequently have you been flossing your teeth? _____

Do your gums bleed? ..... yes_____ no_____

Are your gums sore or swollen? ..... yes_____ no_____

Have your gums receded (do teeth look longer)? ..... yes_____ no_____

Are your teeth loose? ..... yes_____ no_____

Do you smoke or use tobacco products? ..... yes_____ no_____

Do you drink excessively? ..... yes_____ no_____

Do you have a persistent sore throat or ear pain? ..... yes_____ no_____

Do you have unexplained numbness or pain in the face/neck/mouth? ..... yes_____ no_____

Do you have a sore or lesion on the lips or mouth that has persisted for 2 weeks or more? ..... yes_____ no_____

Do you have chronic hoarseness? ..... yes_____ no_____

Do you have difficulty chewing, swallowing, or moving the jaw or tongue? ..... yes_____ no_____

Do you have a lump or thickening in the cheek? ..... yes_____ no_____

Do you snore or have you been told in the past you snore? ..... yes_____ no_____

Do you regularly have excessive daytime sleepiness? ..... yes_____ no_____

Have you been diagnosed with sleep apnea? ..... yes_____ no_____

Do you have a heart condition? ..... yes_____ no_____

Is there a history of heart disease in your immediate family? ..... yes_____ no_____

Do you have a family history of diabetes? ..... yes_____ no_____

Do you have high cholesterol? ..... yes_____ no_____

Do you have any other health conditions? ..... yes_____ no_____

FOR OFFICE USE ONLY

Record Blood Pressure _____

_____

_____

Consent for Use and Disclosure of Health Information

Purpose: In cases where MARK B ARTZER, D.D.S. has directed not to rely on Acknowledgments as a basis to use or disclose health information, this form is used to obtain a patient's consent to our use and disclosure of the patient's protected health information to carry out treatment, payment activities, and healthcare operations, as described more fully in our Notice of Privacy Practices.

AUTHORIZATION FOR USE OR DISCLOSURE OF DENTAL INFORMATION

Patient Name _____

I hearby authorize the use and disclosure of individually identifiable health information relating to me which is called "Protected Health Information (PHI)" under a federal health privacy law, as described below:

Person or Persons authorized to share information with:

_____

_____