Thank you for selecting Blairsville Dentistry!
We will strive to provide you with the highest quality dental care.
To help us meet all of your dental healthcare needs, please complete this form. If you have any questions or need assistance please ask us – we will be happy to help.
(please print and complete in ink)

*Patient #*______________
SS#/SIN ______________

Patient Information (CONFIDENTIAL)

Name ______________________________ Birthdate__________ Date______________________

Address ______________________________ City______________ State/Zip____________________

Phone(H)______________(Cell)______________Email________________________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If student, Name of School/College____________________City____________State________ ☐ Full/ ☐ Part Time

Patient/Parent/Guardian's Employer ______________________________ Work Phone ___________

Business Address______________________________City______________State_______zip__________

Spouse/Parent/Guardian's Name ________________ Employer________________Wk Phone________

Whom may we thank for referring you? ____

Person to contact in case of emergency______________________________Phone______________

List your three main concerns/reasons for scheduling an appointment: 1.______________2.____________
3. ________________ other:______________________________________

Responsible Party

Account Responsible Party____________________Relationship to Patient______________

Address ____City/State ___________

Phone (H) __________ (Cell)______________(Work)__________ Email______________

Driver's License #______________Birthdate____________SS#/SIN____________________

Employer____

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check ☐Visa ☐ MasterCard ☐ Care Credit ☐ *I wish to discuss the office's payment policy*

Insurance Information

Name of Insured____Relationship to Patient______________

Birthdate____________________SS#/SIN ________________Date Employed________________

Name of Employer________________Union/Local #____________Work Phone________________

Address of Employer______________City__________________State/Zip________________

Insurance Company________________Group#________________Policy ID#________________

Ins. Co Address________________City__________________State/Zip________________

Deductible Amount________________Amount used to Date__________ Max. Annual Benefit______________

DO YOU HAVE ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured____Relationship to Patient______________

Birthdate____________________SS#/SIN ________________Date Employed________________

Name of Employer________________Union/Local #____________Work Phone________________

Address of Employer______________City__________________State/Zip________________

Insurance Company________________Group#________________Policy ID#________________

Ins. Co Address________________City__________________State/Zip________________

Deductible Amount________________Amount used to Date__________Max. Annual Benefit______________

MEDICAL HISTORY

Date Today:___________

PATIENT NAME ____ Birth Date ____________________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	If yes, please explain: ____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: ____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: ____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain: ____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	
Do you need to pre-medicate?	Yes	No	If yes, please explain: ____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain:

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain: ____
____
____

Comments: ____
____
____
____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ____ DATE _____________________

Office Policies and Financial Agreement

Thank you for choosing Blairsville Dentistry for your dental care. We consider it an honor to have been chosen. Our philosophy in serving you is to be informative, honest, and forthright, especially in the area of finances.

This financial agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our financial policy, please do not hesitate to ask our Office Manager.

Dental Insurance: As a courtesy, we will gladly file your claims to your insurance company, as you agree to the following:

- You must provide us with an insurance card with all the necessary information to verify your insurance and to file your claim(s).
- YOUR insurance policy is a contract between you, your insurance company, and in some cases your employer. We are NOT party to your contract. Our relationship is with you and not your insurance company.
- You are responsible for our fees and not what your insurance company allows or considers as their “usual and customary fee schedule,” all of which vary from one company to another, unless we are In-Network with your insurance company.
- Although we may estimate your insurance benefits, we are not responsible for their accuracy. Knowledge of your policy, benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc., is entirely YOUR responsibility. Receiving our services indicates your acceptance of your responsibility to pay regardless of our estimate.
- All charges not paid by your insurance company are YOUR responsibility regardless of the reason of non-payment (please see our Financial Policy). Not all of the services we provide are covered benefits and benefits vary from one insurance company to another. Fees for non-covered services, along with deductibles and co-payments are due at the time of treatment.

Payment Policy

- We accept cash, personal checks, Visa, MasterCard, American Express, Discover, and CareCredit.
- A $25.00 fee will be applied to your account for returned checks.
- On your date of service, you are expected to pay what is our estimate of your portion of your claim. After dental insurance has paid its portion a statement will be sent to your mailing address of record for any remaining balance. Full payment of your remaining balance is expected and due upon receipt of this statement. If for any reason your insurance carrier does not pay your claim in full within thirty (30) days all charges become your responsibility to pay in full. A statement will be sent to you from our office indicating a balance due.

- Payment for non-insurance patients is expected in full at the time of service or you may apply for our CareCredit Option Plan to cover your charges. Approval for CareCredit just takes minutes.

Cancellation Policy

Your appointment time is valuable and has been reserved specifically for you. If you are unable to keep your scheduled appointment, we do request at least 24 hours advance notice or a $50 missed appointment fee may be applied to your account. New patients may be required to pay for their appointment in full prior to being rescheduled.

Overdue Balances

An account with an unpaid balance over sixty (60) days will automatically be placed with our collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt that includes any fees our practice is charged from the collection company. Billing and interest charges not to exceed 15.4% may also be applied to your account after thirty (30) days.

Minor Patients

All minor children must be accompanied by a parent or guardian at each visit. The parent/guardian accompanying the minor child on the day of service is responsible for any balance due or fees charged on that day.

Authorization to Treat

I grant Blairsville Dentistry, LLC the authority to administer dental x-rays, local injections, and anesthetics in the subsequent treatment of my case or in case of a minor child I am representing. If I or the patient I am representing has a medical condition, such as a heart murmur that requires premedication, I acknowledge that it is my responsibility to inform the Doctor on staff, the Assistant, or the Hygienist.

I have read, understand and agree to the Office Policies and Financial Agreement details above.

____

Patient or Parent/Guardian Signature Date

____

Print Patient's Name

Also, I have received a copy of this office's NOTICE OF PRIVACY PRACTICES.

____

Patient or Parent/Guardian Signature Date