Sunshine Dental
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Bonham, TX 75418

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Patient Information

Patient Name: _____ Date:_____
Last First

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work): _____ Ext:_____ Cell:_____
Please list at least two contact numbers.

Email Address:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____
Reason for today's visit: _____

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

☐ AIDS
☐ Allergies _____
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Hay Fever
☐ Latex
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Head Injuries
☐ Heart Disease
☐ By Pass Surgery
☐ Valve Replacement
☐ Pacemaker
☐ Heart Murmur
☐ Hepatitis **A, B, C, D, E**
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnant (Currently)
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease

OTHER:
_____
_____

Current Medications:
(List all Medications you are taking)
_____
_____
_____
_____

- 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:_____

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

Parent or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ Check if address is the same as above

Name: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Insurance Information

The following is for: ☐ Self ☐ Patient's spouse ☐ Dependent Child ☐ Other (Please specify)_____

Name of Insured:_____ Is insured a patient? ☐ Yes ☐ No
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Insured's Birth Date: _____ ID #: _____ Group #:_____

☐ Check if address is the same as previous page

Insured's Address: _____
Street City State Zip Code

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

Address: _____
Street Apartment #

_____
City State Zip Code

Insured Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Plan Name and Address: _____

Insurance Patients Please Read Carefully

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

_____ **Date:** _____ **Relationship to Patient:** _____
Signature of patient or guarantor of payment/responsible party

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 for in cash at the time services are performed. *If Patient requests transfer of radiographs to another dentist a Twenty five dollars ($25) duplication fee will be charged.*

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

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 telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content. I have also had the opportunity to review and agree to the HIPPA privacy forms.

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

Sunshine Dental Financial Agreement:

- We appreciate you choosing our office for you and your family's dental care. At Sunshine Dental Dental Care, we value our relationship with you and your family and would like to offer the following as our payment policy.

- If insurance benefits are assigned to the doctor, you will be responsible for paying your deductible and co-payments at the time of service. You are responsible for paying all charges not covered by your insurance company, including all fees considered above your insurance company's usual and customary fee schedule. **Your insurance benefits are a contract between you and your employer.** The amount of coverage you receive will depend on the quality of the plan purchased by your employer, not the fees of Downtown Dental.

- In case of insurance, we will be happy to help you receive the maximum benefits available under your policy. **As a courtesy**, we will check your benefits and file your insurance benefits for you after every visit. **However, please realize that the relationship is between you, the insured, and your insurance company. If we do not receive payment from your insurance company within 60 days after submission of a claim, for ANY REASON, you will be expected to pay for all dental services in full.** In the event of duplicate payments, your account will be reimbursed.

- A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. After 90 days all outstanding accounts will be transferred to PCR & Associates, a debit collection agency. Any an all collection charges, 30%-40% will apply to the outstanding account.

- Once the treatment plan and estimated insurance benefits are reviewed with you, we ask that you pay your portion in full at the time of service.

- Please note that parents or guardians bringing the child into the office on the day of the service will be expected to pay for services rendered.

- If Patient requests transfer of radiographs to another dentist a Twenty Five Dollars ($25) duplication fee will be charged.

I have read and understand the payment policies for the office:

_____ _____

Patient/Parent/Guardian Name (**printed**) Patient/Parent's/Guardian's Signature

_____

Date

Missed appointments and Cancellation Guideline

Appointments and Cancellations

We understand that situations may arise that make it difficult to keep a confirmed appointment. So that all of our patients can receive the care they need, we request at least 48 business hours notice of any change to your scheduled appointment time. This consideration allows the time to identify and serve another patient that would benefit from your previously reserved appointment time.

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. We reserve a set amount of time for your appointment in order to provide the best treatment possible for your dental needs.

Therefore, we charge $45 for failing to show up or cancelling within 48 business hours of scheduled appointments.

We are blessed to have considerate patients who keep their word diligently. We look forward to continuing to serve you and your family with integrity and compassion.

If you are unable to keep a scheduled appointment, please give 48 hours notice to ensure that you will not be charged for the appointment.

If less than 48 hours notice is given, you will be expected to pay $45.00 for the appointment.

Thank you!

_____ _____

Patient/Parent/Guardian Name (**printed**) Patient/Parent's/Guardian's Signature

_____

Date