WELCOME

We would like to Thank You for choosing us for your dental needs. We will do our best to provide you with the best care and treatment possible. If you have any questions we'll be glad to answer them for you.

PATIENT INFORMATION

Date _____

Home Phone(____)_____ Cell Phone(____)_____ Work Phone(____)_____

Name_____ Social Security # _____

Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex: _____Male _____Female _____Age Birth date _____

_____ Married _____ Widowed _____ Single _____Separated _____ Divorced _____ Partnered for _____ years

Patient Employer/School _____ Occupation_____

Employer/School Address _____ Employer/School Phone (_____)_____

Person Responsible for the Account _____ Relationship _____ Phone (_____)_____

Address if different from above _____

Whom may we thank for referring you? _____

In case of an emergency who should be notified? _____ Phone (_____)_____

Patient's Last Cleaning appointment? _____Last x-rays? _____

Reason for today's appointment? _____ Former Dentist? _____ Phone (_____)_____

Please note that a parent/guardian must remain on premises during the entire visit for any patient under 18 years of age, as required by law. Signed (Parent/Guardian):_____ Date: _____

PRIMARY DENTAL INSURANCE

Subscriber's Name_____ Birth date _____ Relation to Patient _____

Address (if different from patient's) _____

City State Zip

Phone (_____)_____ Sex: _____Male _____ Female Social Security # _____

Employer _____ Occupation _____

Business Address _____ Business Phone (_____)_____

Name of Insurance Company _____ Insurance Phone (_____)_____

Insurance Company's Claim Mailing Address _____

City _____ State _____ Zip _____

Identification # _____ Group # _____

ADDITIONAL DENTAL INSURANCE

Subscriber's Name_____ Birth date _____ Relation to Patient _____

Address (if different from patient's) _____

City State Zip

Phone (_____)_____ Sex _____Male _____ Female Social Security # _____

Employer _____ Occupation _____

Business Address _____ Business Phone (_____)_____

Name of Insurance Company _____ Insurance Phone (_____)_____

Insurance Company's Claim Mailing Address _____

City _____ State _____ Zip _____

Identification # _____ Group # _____

AUTHORIZATION

I certify that I, and/or my dependents(s) have the above insurance coverage and assign directly to Dr. E. Riggs Leach, III, DDS all insurance benefits, if any, otherwise payable to me for services rendered. I also understand that if I received any insurance payments for services rendered I am responsible to forward those amounts to the office of Dr. E. Riggs Leach, III, DDS. I further understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Signed:_____ Print: _____ Date:_____

Relation to Patient:_____ Patient's Name (Print):_____

MEDICAL HISTORY

Have you ever been told that you need to PRE-MEDICATE prior to dental treatment (Heart Murmur, Artificial Joint, Rheumatic Fever)? ____Yes ____No

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 taken Fosamax, Boniva, Actonel or any other medications containing Bisphosphonates? ____Yes ____No

Are you taking blood thinners? ____Yes ____No

Do you or have you ever experienced Dry Mouth? _____Yes ____No

Do you use tobacco? _____Yes _____No

Do you use controlled substances? _____Yes _____No

List all current medications, including over the counter medications, vitamins and/or supplements:

Medication	Dosage	Condition

WOMEN: Are you:

Pregnant/Trying to get pregnant: ___Yes ___No Taking Oral contraceptives? ___Yes ___No Nursing? ___Yes ___No

ALLERGIES: Are you allergic to any of the following?

___Aspirin ___Penicillin ___Codeine ___Local Anesthetics ___Acrylic ___Metal ___Latex ___Sulfa Drugs

___Other If yes please explain:_____

Do you have, or have ever had, any of the following:

___AIDS/HIV Positive	___Congenital Heart Disorder	___Hepatitis A	___Renal Dialysis
___Alzheimer's Disease	___Cortisone Medicine	___Hepatitis B or C	___Rheumatic Fever
___Anaphylaxis	___Diabetes	___Herpes	___Scarlet Fever
___Anemia	___Drug Addiction	___High Blood Pressure	___Sickle Cell Disease
___Angina	___Emphysema	___High Cholesterol	___Sinus Trouble
___Arthritis/Gout	___Epilepsy/Seizures	___Hypoglycemia	___Stomach/Intestinal Disease
___Artificial Heart Valve	___Excessive Bleeding	___Leukemia	___Stroke
___Artificial Joint	___Fainting Spells/Dizziness	___Liver Disease	___Thyroid Disease
___Asthma	___Frequent Headaches	___Low Blood Pressure	___Tuberculosis
___Blood Disease	___Genital Herpes	___Mitral Valve Prolapse	___Ulcers
___Breathing Problem	___Heart Attack/Failure	___Osteoporosis	___Venereal Disease
___Cancer	___Heart Murmur	___Pain in Jaw	
___Chemotherapy	___Heart Pacemaker	___Psychiatric Care	
___Cold Sores/Fever Blister	___Hemophilia	___Radiation Treatments	

Have you ever had any serious illness not listed above? ____Yes ____No Explain:_____

HIPAA

My signature confirms that I, (Patient's Name)_____, have been informed of my rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). Revisions to the Notice of Privacy Practices will be posted on the effective date and I am aware that I may request a written copy of the Revised Notice from this office.

Signed (Patient, Parent/Guardian):_____ Date:_____

Person(s) that representatives of Leach Family Dentistry are authorized to speak with regarding my dental, medical, or financial situations:

Name (Print):_____ Relationship:_____ Phone:(_____)_____

Name (Print):_____ Relationship:_____ Phone:(_____)_____

FINANCIAL AGREEMENT

I understand that payment for services rendered are due on the date that services are rendered, including any insurance co-payments and/or deductibles. Any insurance claim not paid by the insurance carrier within 90 days will become the subscribers responsibility. Any account balance that exceeds 30 days, from the date of service, with no or insufficient payment will be subject to a 1.25% finance charge and that a $10.00 per month billing fee will be applied to all accounts where a statement must be generated to collect payment. A **minimum** fee of $50.00 will be charged for families where one or more members miss or cancel, with less than 24 hours notice, more than one appointment in 12 consecutive months. All fees charged to our office for returned checks will be applied to the account balance. Any account 90 days past due is subject to be turned over to a collection agency; any fees for collection and/or legal processing will be applied to the account balance.

Signed (Patient, Parent/Guardian):_____ Print:_____ Date:_____