



PATIENT HISTORY & INFORMATION

Patient Name _____ Birth Date _____ Age _____ Sex _____
 Address (HOME) _____ Drivers License # _____ Marital Status _____
 City _____ Zip _____ Phone (HOME) _____
 Employer _____ Occupation _____
 Address (BUSINESS) _____ Social Security # _____
 City _____ Zip _____ Phone (BUSINESS) _____
 Change of Address or Employer, if any: _____

SPOUSE OR PARENT INFORMATION

Name _____ Relationship _____ Social Security # _____
 Address _____ Drivers License # _____
 Employer _____ Occupation _____ Phone _____

PLEASE ANSWER EACH QUESTION

1. Have you been a patient in a hospital during the past 2 years? Yes No
2. Have you been under the care of a physician during the past 2 years? Yes No
For What? _____
3. Have you taken any kind of medicine or drugs during the past 2 years? Yes No
Currently _____
4. Have you ever had any excessive bleeding requiring special treatment? Yes No
5. (Women) Are you pregnant? Yes No
6. Have you ever had any of the following diseases or medical problems?

Y N Heart Attack/Stroke	Y N Artificial Valves	Y N Hemophilia/Abnormal Bleeding
Y N Cancer/Chemotherapy	Y N Sinus Problems	Y N Ulcers/Colitis
Y N Heart Murmur	Y N High/Low Blood Pressure	Y N Congenital Heart Defect
Y N Rheumatic Fever	Y N Fever Blisters	Y N Anemia/Radiation Treatment
Y N HIV+/Aids	Y N Severe/Frequent Headaches	Y N Asthma/Arthritis
Y N Heart Surgery/Pacemaker	Y N Psychiatric Problems	Y N Difficulty Breathing
Y N Shingles	Y N Epilepsy/Seizures/Fainting	Y N Emphysema/Glaucoma
Y N Mitral Valve Prolapse	Y N Diabetes/Tuberculosis (TB)	Y N Hepatitis
Y N Kidney Problems	Y N Drug/Alcohol Abuse	Y N Blood Transfusion
Y N Artificial Bones/Joints	Y N Venereal Disease	Y N Hospitalized for Any Reason

Please list any serious medical condition(s) that you have ever had: _____

7. Physician's Name and Phone Number _____

8. Are you allergic to any of the following drugs?

Y N Penicillin	Y N Tetracycline	Y N Latex	Y N Dental Anesthetics
Y N Aspirin	Y N Codeine	Y N Erythromycin	Y N Other _____

9. How long has it been since your last dental visit? _____

10. What is your previous dentist's name? _____

11. Who referred you to this office? _____

12. CHIEF DENTAL CONCERN: _____

I understand that the information that I have given today is correct to the best of my knowledge.

 Patient or Parent/Guardian (if minor) Date: _____ D.D.S. Signature Date: _____

FINANCIAL & INSURANCE INFORMATION

Bill will be paid by: Self _____ Insurance _____ Other _____

PRIMARY INSURANCE COVERAGE

Address _____
City, State, Zip _____
Telephone Number () _____
Insured Person _____ Relationship _____
Social Security# _____ Birthdate _____
Employer _____ Group Plan Name _____
Policy Number _____ Group Number _____

SECONDARY INSURANCE COVERAGE

Address _____
City, State, Zip _____
Telephone Number () _____
Insured Person _____ Relationship _____
Social Security# _____ Birthdate _____
Employer _____ Group Plan Name _____
Policy Number _____ Group Number _____

OFFICE USE

Effective Date of Coverage _____ Waiting Period _____
Deductible per Year or Lifetime _____ Maximum Limit per Year _____
Exclusions or Exceptions _____

Coverage:

_____ % Preventative
_____ % Basic
_____ % Major

Deductible applied to:

_____ Preventative
_____ Basic
_____ Major

Number of cleanings per year _____ X-rays allowed _____

AUTHORIZATION TO RELEASE INFORMATION: I authorize my dentist to release any information or x-rays to my insurance company for any oral or dental observation, treatment, services or benefits rendered or payable to me or in my behalf or in behalf of my eligible dependents.

Signed _____ Date: _____
Patient or Parent/Guardian (if minor)

AUTHORIZATION TO PAY BENEFITS TO DENTIST: I authorize payment directly to Dr. Coe otherwise payable to me.

Signed _____ Date: _____
Patient or Parent/Guardian (if minor)

MEDICAL HISTORY UPDATE

1. Date _____ Comments _____ Signature _____
2. Date _____ Comments _____ Signature _____
3. Date _____ Comments _____ Signature _____

Robert L. Coe, D.D.S., Inc.

THANK YOU for selecting us as your personal dental care team. To promote a long-term mutually satisfying relationship, we would like to explain our office policy regarding treatment, insurance, appointments and fees. **PLEASE**, read this agreement carefully and ask any questions or bring up any concerns you may have **BEFORE** treatment is rendered. **SUBMISSION TO TREATMENT IMPLIES YOUR CONSENT TO THE TERMS OF THIS AGREEMENT.**

TREATMENT: You will find our entire staff is dedicated to helping you improve your dental health as quickly as possible. Every effort will be made to make your appointment as comfortable and pleasant as possible. Please feel free to discuss your treatment with the doctor at any time.

INSURANCE: If this office is able to accept your insurance company's assignment, the patient is still **FULLY RESPONSIBLE** for the charges for treatment rendered. Your insurance **MAY NOT COVER** the services or may only **PARTIALLY** cover them and any **ESTIMATE** given by this office is considered a **GUIDELINE** until the final insurance is received and the patient's account is reconciled. The office can make **NO GUARANTEE** of actual payment by your insurance company.

MISSED APPOINTMENTS: When we schedule your appointment, the time is reserved exclusively for you. When you fail to notify us of your inability to keep an appointment, another patient in need of dentistry is unable to receive treatment. We request that you give us at least 24 hours notice when you realize that you cannot keep an appointment. When the requested notice is not given, a fee of \$25.00 per half hour scheduled will be charged. For those whose schedules make it difficult to effectively plan ahead, we ask that you do not schedule an appointment in advance, but that you call us the day you can come in and we will be happy to see you then—provided the time is available.

PAYMENT IS DUE AT THE TIME OF SERVICE: We accept cash, personal checks, Master Card, Visa, Discover and American Express. When insurance applies, we will collect any deductible and estimated co-payment at this time.

We have two payment options available for patients needing extensive dental work. Both must be approved before services are rendered. Please ask Laurie for more information if interested.

SERVICE CHARGES:

1. **MONTHLY BILLING:** Even though an insurance claim has been filed, you will receive a statement each month if there is a balance due on your account, since you, not the insurance company, are responsible for payment of your account. A \$3.00 charge will be applied every month to accounts with balances outstanding 60 days or longer, regardless of outstanding insurance.
2. **RETURNED CHECKS:** There is a \$15.00 fee for returned checks. The check must be picked up personally and cash must be paid to cover the check and the fee.
3. **COLLECTION FEES:** Fees incurred to enforce payment required by this agreement will be charged to the patient whose failure to pay, required these fees to be incurred.

SIGNATURE: _____ **DATE** _____
Patient/Parent or Guardian if patient is a minor