FINANCIAL POLICY

We welcome you as a patient and appreciate your business! As a patient of Dr. Hendry's, you are responsible for payment at the time of service which includes any deductible assessed by your insurance company unless other arrangements have been made **prior to the start** of treatment. Not all services are a covered benefit. Please be sure to review your insurance booklet for accurate coverage. Please note that your insurance policy is a contract between **you, your employer, and your insurance carrier.** We are not a party to that contract.

We **highly** recommend that you know what your insurance benefits are. As a courtesy to you, we will gladly verify them for you, to help maximize your benefits. Verifying your insurance does not guarantee any form of payment or coverage. Insurance is an aide to your payment; it does not cover all procedures in full.

A **$50.00** fee will be assessed to your account for any missed appointments or proper notice of 24 hours is not given. We, as a courtesy to our patients, give a one week reminder and a day before confirmation for any scheduled appointments.

Any collection fees, court costs, reasonable attorney fees, or returned check fees are the responsibility of the adult person(s) (responsible party) named on the account.

Any portion not covered by your insurance is your responsibility and will be billed to you. A monthly service fee of 1.5% per month or 18% per annum will be assessed on all past due accounts. We do our best to **estimate** your patient portion, but cannot guarantee any form of payment by your insurance company.

I, _____, assign payment directly to Hendry Dental for all dental services rendered.

_____ _____

Patient Name Date

_____

Patient or Legal Guardian Signature

General Consent

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.

Benefits of dental treatment can include: Relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1. **Drug and chemical reaction.** Dental materials and medications may trigger allergic or sensitivity reactions.
2. **Long-term numbness (paresthesia).** Local anesthetic, or its administration, while most always adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness.
3. **Muscle or joint tenderness.** Holding one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate a TMJ disorder.
4. **Sensitivity in teeth or gums, infection or bleeding.**
5. **Swallowing or inhaling small objects.**

While we follow procedural guidelines, which most often lead to a clinical success, just like in any other pursuit in healthcare, not everything turns out the way it is planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you.

I have read and understand the statements on this page.

_____ _____

Patient Name Date

_____

Patient, parent or legal guardian signature (if patient is a minor)

WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

SECTION 1 – Personal Information

Date _____
Birthdate _____
SS#/SIN _____
Name _____
Wishes to be called _____

Male	Female	Minor	Single	Married	Divorced	Widowed	Separated
_____	_____	_____	_____	_____	_____	_____	_____

Address _____
City _____ State _____ Zip _____
Employer _____ Occupation _____
Referred by _____

SECTION 2 – Responsible Party

Who is responsible for the account?
Name _____
Relationship to patient _____
Birthdate _____ Driver's License # _____
SS#/SIN _____ Email _____
Address _____
City _____ State _____ Zip _____
Employer _____
Occupation _____
Work Phone _____ Ext # _____
Home Phone _____ Cell Phone _____

SECTION 3 – Telephone

Home Phone _____
Work Phone _____ Ext # _____
Cell Phone _____
Where do you prefer to receive calls? Home _____ Work _____ Car _____
When is the best time to reach you? Time_____ Days _____
In the event of an emergency, who should we contact? _____

SECTION 4 – Dental Insurance Information

Primary Insurance

Name of Insured _____
Relationship to patient _____
Insured's birthdate _____
SS#/SIN _____
Employer _____
Date Employed _____
Occupation _____

Insurance company _____
Group # _____
Employee/Cert. # _____
Ins Co. Address _____
Deductible _____
Amount already used _____
Max annual benefit _____

Additional Insurance

Name of Insured _____
Relationship to patient _____
Insured's birthdate _____
SS#/SIN _____
Employer _____
Date Employed _____
Occupation _____

Insurance company _____
Group # _____
Employee/Cert. # _____
Ins Co. Address _____
Deductible _____
Amount already used _____
Max annual benefit_____

SECTION 5 – Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners.
I authorize and request my insurance company to pay directly to the dentist or dental group, insurance benefits otherwise payable to me.
I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____
Signature of patient or parent/guarding if minor Date

SECTION 6 – Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer. Payment in full due at each appointment.
_____ Cash
_____ Personal Check
_____ Credit Card _____Visa _____ MC _____ Other
_____ I wish to discuss the dental office's policy.

Late Charges
If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental hearlthcare needs more effectively and efficiently. If you have any questions at any time, do not hesitate to contact our office.

HEALTH HISTORY

NAME_____BIRTHDATE_____ TODAY'S DATE_____

Dental History

1. Reason for visit
   _____
   _____
2. When was your last dental visit?
   _____
   _____
3. How often do you brush your teeth?
   _____
4. What texture brush do you use? ____ Soft ____ Medium ____ Hard
5. Do your gums bleed while brushing?
6. Do your gums bleed while flossing?
7. Do you feel pain to any of your teeth when brushing or flossing them?
8. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids?
9. Have you noticed any loosening of your teeth?
10. Does food tend to become caught between your teeth?
11. Do you have any sores or lumps in or near your mouth?
12. Have you ever experienced any of the following problems in your jaw?
    a. Clicking?
    b. Pain (joint, ear, side of face)?
    c. Difficulty in opening or closing?
    d. Difficulty in chewing?
13. Have you had any head, neck or jaw injuries?
14. Do you have frequent headaches?
15. Do you clench or grind your teeth while awake or asleep?
16. Do you bite your lips or cheeks frequently?
17. Have you ever had:
    a. Orthodontic treatment (braces)?
    b. Oral Surgery?
    c. Gum treatment?
    d. Your teeth ground or the bite adjusted?
    e. Worn a bite plane or other appliance?
18. Are you satisfied with the appearance of your teeth?
19. Have you ever had an upsetting experience in the dental office?
20. Is there anything about having dental treatment that bothers you?

Medical History

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 that you will be receiving. Thank you for answering the following questions.

1. Are you in good health?
2. Have there been any changes in your general health within the past year?
3. Date of your last physical exam:
   _____
4. Physician's name
   _____
   Address _____
   Phone No. _____
5. Are you now under the care of a physician?
6. Have you ever been hospitalized for any surgical operation or serious illness? Please explain
   _____
   _____
   _____
   _____
   _____
7. Are you taking any medicine(s) including non-prescription medicine?
   If yes, what medicine(s) are you taking?
   _____
8. Have you ever taken Fen-Phen/Redux?
   _____
9. Have you had any abnormal bleeding?
10. Do you bruise easily?
11. Have you ever required a blood transfusion?
12. Have you had a recent weight loss?
13. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?
14. Do you use tobacco?
15. Do you use alcohol or cocaine or other drugs?
16. Are you wearing contact lenses?
17. Do you have any disease, condition or problem not listed above that you think I should know about?

WOMEN ONLY:

1. Are you pregnant or think you may be pregnant?
2. Are you nursing?
3. Are you taking birth control pills?

Are you allergic to or have you had reactions to:

1. Local anesthetics like novocaine?
2. Penicillin or other antibiotics?
3. Sulfa drugs?
4. Barbiturates, sedatives or sleeping pills?
5. Aspirin?
6. Iodine?
7. Other?

Do you have or have you ever had the following:

1. Rheumatic heart disease or rheumatic fever?
2. Scarlet fever?
3. Heart defect or heart murmur?
4. Heart trouble, heart attack, or angina?
    a. Do you have pain in your chest upon exertion?
    b. Are you ever short of breath after mild exercise?
    c. Do your ankles swell?
    d. Do you get short of breath when you lie down?
    e. Do you require extra pillows when you sleep?
5. Pacemaker?
6. Heart surgery?
7. High blood pressure?
8. Low blood pressure?
9. Hepatitis, jaundice or liver disease?
10. Stroke?
11. Sinus trouble?
12. Lung or breathing problems?
13. Asthma or hay fever?
14. Hives or skin rash?
15. Fainting spells or seizures?
16. Diabetes?
17. AIDS or HIV infection?
18. Thyroid problems?
19. Allergies?
20. Arthritis or rheumatism?
21. Joint replacement or implant?
22. Stomach ulcer?
23. Kidney trouble?
24. Tuberculosis?
25. Persistent cough?
26. Cough that produces blood?
27. Cancer?
28. Sexually transmitted disease?
29. Epilepsy?
30. Anemia?
31. Leukemia?
32. Glaucoma?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information van 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 legal guardian Date

FOR COMPLETION BY THE DENTIST:

Summary of Dental History:

Summary of Medical History:

Medical History Update:

Date	Comments	INITIALS Patient	Dentist	Hygienist
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____