KEYSTONE
DENTAL EXCELLENCE
Personalized & Comfortable

Patient Information:

Name: _____ Date: _____

Social Security #: _____ Birthdate: _____ Home Phone: _____

Alternate Phone(Cell, Work): _____ Email address: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Person: _____ Phone Number: _____

Whom May We Thank for Referring you? _____

Responsible Party: ☐ Check if the same as above

Name of Person Responsible for this Account: _____

Relationship to the Patient: _____ Driver's License #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Birthdate: _____ Social Security #: _____

Employer: _____ Work Phone: _____

Dental Insurance Information:

Name of Insured: _____ Relationship to Patient: _____

Birthdate: _____ Social Security # : _____

Name of Employer: _____ Work Phone: _____

Insurance Company: _____ Group #: _____

Your payment is due in full at each appointment. For your convenience, we accept the following methods of payment: Cash, Visa, MasterCard and Discover. Personal checks accepted with Doctor approval.

We respect your time, therefore, we will do our very best to see you at your scheduled appointment time. In return, we ask that you are on time for your appointments. We also ask for a minimum of 48 hours notice if you need to reschedule your appointment so that we may give your appointment time to another patient. A pattern of broken appointments will result in your dismissal from the practice.

Patient Medical History:

Your name: _____ Today's Date: _____

Are you under medical treatment now? Yes No

Have you ever been told to pre-medicate (ie, take an antibiotic) before dental treatment? Yes No

List any medications (including non-prescriptive medicine) you are currently taking:

_____

_____

List any medications you are ALLERGIC to or have had an ADVERSE REACTION from:

_____

_____

Women Only:

Are you pregnant or think you may be pregnant? Yes No
Are you nursing? Yes No
Are you taking oral contraceptives? Yes No

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

High Blood Pressure	Yes	No	Cardiac Pacemaker	Yes	No
Heart Attack	Yes	No	Heart Murmur	Yes	No
Rheumatic Fever	Yes	No	Chest Pain	Yes	No
Seizures/Epilepsy	Yes	No	Anemia	Yes	No
Asthma	Yes	No	Cancer	Yes	No
Diabetes	Yes	No	Mitral Valve Prolapse	Yes	No
Kidney Disease	Yes	No	Liver Disease/Hepatitis	Yes	No
AIDS or HIV	Yes	No	Joint Replaced/Implants	Yes	No
Heart Disease	Yes	No	Stroke	Yes	No
Tuberculosis	Yes	No	Other: _____		

Are your teeth sensitive or painful? Yes No
Do you clench your teeth? Yes No

Are you interested in cosmetic procedures, such as whitening, veneers or clear braces? Yes No

What is the most important to you about your dental health? _____

Authorization and Release:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. 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, if patient is a minor) Date

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Office Policy and Financial Agreement

All patients, please read the following…

Payment for services is expected at the time service is provided. Cash, Visa, Mastercard, and Discover are accepted. Personal checks may be accepted with Doctor approval. Capital One Healthcare Finance Options is available if an extended payment plan is desired.

All services provided to you, your dependents, or others assigned by you to your account are charged directly to you. You are personally responsible for payment. If you suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable. Should the fees for the professional services not be paid in accordance with the provisions herein, reasonable attorney's fees, plus applicable finance charges and disbursements, allowances and costs provided by law shall be included in the computation of the amount due. Finance charges can be applied to all past due amounts (older than 30 days) at the rate of 1.5% per month (18% annual rate). If the account is in default and turned over for collections, a collection fee will be added, which may be up to 60% of the amount owed.

A returned check will result in a $25 service charge **and** all future payments being in the form of cash or credit card.

If you have dental insurance, please read the following…

We must emphasize that as dental providers, our relationship is with you, **not** your insurance company. We deliver the appropriate care to our patients based upon clinical need and not based on insurance coverage or reimbursement.

Your co-payment and deductible will be **due at the time of treatment**. Your co-payment will be an estimated amount only. If we over-estimate your portion, we will issue you a refund or leave the amount as a credit on your account to be used as you wish. If we under-estimate your portion, you will receive a bill for the remaining amount due.

We do our best to estimate your co-payment amount but please understand that it is based on the information given to us by you and your insurance at the time inquiry. Therefore, **the estimate we provide you may be incorrect**. You are responsible for any amount due on the account after the claim is processed and paid by your insurance company.

All services rendered are charged directly to the patient and **you are ultimately responsible for the account regardless of insurance coverage, benefits or payments.** Not all services are a covered benefit in all contracts. **You, however, are still responsible for those charges.** It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance policy. **Any insurance claims denied or remaining unpaid after 60 days will automatically become your responsibility to pay and will be considered due in full.**

Missed Appointments/Cancelled Appointment Policy…

We respect your time, therefore, we will do our very best to see you at your scheduled appointment time. In return, we ask that you are on time for your appointments. We also ask for a minimum of 48 hours notice if you need to reschedule your appointment so that we may give your appointment time to another patient. A pattern of broken appointments will result in your dismissal from the practice.

Insurance Authorization and Assignment of Benefits…

I hereby authorize Dr. Reinhart to furnish information to insurance carriers concerning me or my dependents' treatments and I hereby assign to the dentist all payments for services rendered to me or to my dependents. I understand that I am responsible for any amount not covered by insurance.

Print Name: _____

Signature: _____ Date: _____