Mark S. Walker, D.M.D Suzanne Land, D.M.D

Health History

Name_____ Date_____

Do you have, or have you ever had any of the following: (Please Circle yes or no)

UPDATE

YES NO Acid Reflux
YES NO Anemia
YES NO Arthritis
YES NO Artificial Joints (Date)_____
YES NO Asthma
YES NO Cancer, Leukemia
YES NO Diabetes/Hypoglycemia
YES NO Epilepsy or seizures
YES NO Excessive Bleeding
YES NO High Cholesterol
YES NO Heart Attack
YES NO Mental Health Treatment
YES NO Heart Valve Replacement
YES NO Hepatitis
YES NO Rheumatic Fever
YES NO High Blood Pressure
YES NO Kidney Disease
YES NO Liver Disease
YES NO Osteoporosis/Osteopenia
YES NO Pacemaker
YES NO Radiation Treatment
YES NO Stroke
YES NO Seasonal Allergies
YES NO Thyroid Disorders
YES NO Tuberculosis
YES NO Heart disease or A Fib

Office Use Only
_____20___
_____20____
_____20____
_____20____
_____20_____

Are you taking or have you taken any of the following:

YES NO Anticoagulants (blood thinners)
YES NO Bisphosphonates/ Bone Density Drugs (Fosamax, Boniva, Actonel, Reclast, Aredia, Zometa, etc..)
YES NO Do you use tobacco?_____
Do you need to pre-medicate for treatment? YES NO Reason_____
If yes what do you take?_____

Are you allergic to any of the following:

YES NO Local anesthetics_____
YES NO Antibiotics (Penicillin, Sulfa drugs. etc)_____
YES NO Aspirin
YES NO Codeine
YES NO Latex
YES NO Foods (Dairy, soy products, etc.)_____
Other Known Allergies_____
YES NO Have you had any problems associated with any dental treatment?
If yes_____
YES NO Are you pregnant? YES____ Are you nursing? YES___NO___

Do you have any other medical issues not listed? _____

Please list your medications:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Patient Signature_____ Guardian Signature_____

Date_____ Date_____

Patient Information

Patient Name_____ SS#_____ Date_____

Patient's Address_____
Street City State Zip

Patient's Phone #_____ Cell Phone #_____ DOB_____

Emergency Contact_____ Relationship_____ Phone_____

Place of Employment_____ Occupation_____

Employers Address_____ Employers Phone #_____

Whom may we thank for referring you?_____ **Your email**_____

Dental Insurance Information

Name of Primary Insured_____
Last First MI

Insured's DOB_____ Age_____ Insured's Social Security Number_____

Name of Insurance_____ Group #_____ ID #_____

Insurance Address_____
Street City State Zip

Insured's Address If different than patient_____
Street City State Zip

Secondary Dental Insurance

Name of Insured_____
Last First MI

Insured's DOB_____ Insured's Social Security Number_____

Name of Insurance_____ Group #_____ ID #_____

Insurance Address_____
Street City State Zip

Insured's Address if different than patient_____
Street City State Zip

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.

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.

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 have read the above conditions of treatment and payment and agree to their content.

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.

_____ _____ _____
Signature of patient, parent, insured or guardian Relationship Date

FINANCIAL POLICY

Thank you for choosing our office to provide your dental care. We appreciate your trust and look forward to working with you. In order to prevent any misunderstanding and to better serve you, we ask that all patients read and sign our Financial Policy. If you have any questions please ask the receptionist or office manager.

1. **VERIFYING INSURANCE**: As a courtesy to our patients, we will verify insurance for benefits eligibility prior to the first appointment as well as any time we are notified of a change in coverage. The insurance companies do not guarantee payment based on the information that they provide us. You are ***ultimately responsible*** for knowing the terms of your plan; this includes any waiting periods for work to be performed. Any amount on your treatment plan that is not covered by your insurance, except for contractual fee discounts, is your financial responsibility. ***INITIAL_____***

2. **INSURANCE INFORMATION:** New insurance, as well as changes in insurance, must be provided to our office **prior** to your appointment. Accepting assignment of benefit from your insurance company is the equivalent of extending you credit; therefore we must have your Social Security Number on file. If you choose not to provide us your Social Security Number, you will be responsible for payment in full at the time services are rendered. ***INITIAL_____***

3. **CHANGES IN PERSONAL INFORMATION:** Changes in your address or telephone numbers should be provided to us immediately. If this office is unable to contact you by telephone or mail and your balance is overdue, your account will be sent to a collection agency. ***INITIAL_____***

4. **REQUESTS FOR ADDITIONAL INFORMATION:** These must be responded to immediately. Such requests include proof of a college student's full-time status and proof of continued enrollment in an insurance plan. Failure to provide this information to the insurance company in a timely manner may result in the entire balance being **your**
5. responsibility. ***INITIAL_____***

6. **PAYMENT:** Payment is due **at the time of service**. Additionally, if you have a balance following an insurance payment from a previous visit, you will be expected to pay that amount as well. ***INITIAL_____***

7. **PAYMENT PLANS:** In addition to cash, checks, Visa, MasterCard and Discover, we offer other payment options – please see our business staff or office manager for details. ***INITIAL_____***

8. **BALANCES:** If your account balance exceeds 30 days, you will receive a notice informing you that your account is overdue. If you do not pay your balance or arrange a payment plan within 60 days, your account may be assessed a finance charge of 1.5% per month. If your account is turned over to a collections agency a collection fee (currently $15.00) will be added to your account balance. The collection agency will report any unpaid balance to the major credit bureaus. If, for any reason, the account is litigated, the patient is responsible for all attorney and court fees. ***INITIAL_____***

9. **REFUNDS:** Overpayments will be refunded to the appropriate party, normally the insurance company or the guarantor. Patients' refunds will not be processed until all active or past due accounts and insurance claims have been paid in full. ***INITIAL_____***

10. **RETURNED CHECKS:** There will be a $30 fee for all returned checks. The amount of the check plus the fee must be paid within 10 days of notification by money order, cash or credit card. ***INITIAL_____***

11. **CANCELLATIONS/FAILED APPOINTMENTS:** We request ***2 business days*** if you are canceling an appointment. We reserve the right to charge a **$30** fee for cancellations made without 2 business days notice and for failed appointments ("no shows"). The **$30** will be posted to your account. ***INITIAL_____***

Patient or Guardian Signature_____Date_____

Printed Name of Patient or Guardian_____

Signature of Business Staff Member_____Date_____

Mark S. Walker LLC

Your Privacy Is Important to US

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of Mark S. Walker LLC I hereby authorize, as indicated by my signature below, Mark S. Walker LLC to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print Name Name of Child/Children, if applicable

_____ _____

Signature Date

Please check your preferred means of communication:

- ☐ You may contact me at my home telephone number _____
- ☐ You may contact me on my mobile telephone number _____
- ☐ You may contact me on my work telephone number _____
- ☐ You many send me an email at: _____
- ☐ Other_____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____Date Added / Removed:_____
2. _____Date Added / Removed:_____
3. _____Date Added / Removed:_____
4. _____Date Added / Removed:_____

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices,

But acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please Specify)_____