Dental Care
of Northfield
Patricia Raczka, DDS

Welcome to Our Practice

Please complete and sign this confidential patient information form. Thank you!

Patient Name: _____ **(circle)** Mr. Mrs. Ms. Dr. Rev.

I prefer to be addressed as: _____

Address: _____
Street Address **City, State** **Zip**

Email Address: _____

Telephone: Home: (___)_____ Work: (___)_____ Cell: (___)_____

Where and when is the best time to reach you? _____

(**check one**): __Single __Married __Divorced __Widowed __Separated

Date of Birth: _____/_____/_____ SSN: _____-_____-_____

Employer: _____ There for _____ years

Employer Address: _____
Street Address **City, State** **Zip**

Occupation: _____

Who may we thank for referring you? _____

Other family members seen by us? _____

Spouse's Name: _____ **(circle)** Mr. Mrs. Ms. Dr. Rev.

Date of Birth: _____/_____/_____ SSN: _____-_____-_____

Telephone: Home: (___)_____ Work: (___)_____ Cell: (___)_____

Employer: _____ There for _____ years

Employer Address: _____
Street Address **City, State** **Zip**

Occupation: _____

Medical History

My current medical health is: ___Excellent ___ Good ___ Fair ___ Poor

Are you under the care of a physician? ____ YES _____ NO

Physician Name: _____ Office Location: _____

Office Telephone: _____

Please list all medications you take (prescription and over the counter):

Female Patients: ____Pregnant? ____Nursing? ____Using Birth Control? If yes, what type? _____

Have you ever had any of the following (**Put a Y for 'yes' N for 'no'**)

___Heart Attack ___Heart Surgery ___Mitral Valve Prolapse ___Heart Murmur ___Pacemaker

___Rheumatic Fever ___Scarlet Fever ___Kidney Problems ___Cancer ___Chemotherapy

___Radiation Treatment ___HIV/AIDS ___Shingles ___Artificial Joint ___Artificial Valve Fever

___Blisters ___Cold Sores ___Stroke ___Sinus Trouble ___Epilepsy/Seizures ___Diabetes

___Tuberculosis ___Psychiatric Problems ___Ulcers ___Colitis ___Anemia

___Drug/Alcohol Dependence __Asthma __Arthritis __Emphysema __ Hemophilia/Bleeding

___Venereal Disease ___Fainting ___Glaucoma ___ Difficulty Breathing

___ High/Low Blood Pressure ____Blood Transfusion ___ Headaches – severe/frequent

Hospitalized for: _____

Allergies: Are you allergic or have you had difficulty with any of the following substances? (**Put a Y for 'yes' N for 'no'**)

__Penicillin __Tetracycline __Latex __Aspirin __Codeine __Sulfa __Dental Anesthetic __Erythromycin

Other (**please specify**): _____

Do you exercise regularly? _____YES ____NO

If YES, what do you enjoy doing? _____

The information I have provided is true to the best of my knowledge. I authorize the doctor to take X-rays, study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the services required for my dental health. I understand that the doctor will discuss treatment before it is initiated. I further authorize and consent that the doctor choose and employ such assistance as deemed fit.

Signature: _____ **Date:** _____/_____/_____

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Financial Responsibility Agreement and Consent for Services

Thank you for choosing our team of dental professionals to serve your dental needs. We are committed to providing you with the highest quality care. We appreciate the confidence you have placed in us and will do everything possible to continue to warrant your confidence as we serve you. In order to continue providing outstanding care to all of our patients, we ask that you please understand and agree to the following office financial policy.

Insurance:
Dental insurance is designed to help offset the cost of dental care. Insurance estimates provide a table of allowances that will assist you in determining your approximate out-of-pocket expenses.

1. Filing insurance claims is a courtesy that we will gladly perform for you to help you maximize your benefits. However, you are responsible for any amount not covered by your insurance, *whatever the reason.*
2. On your behalf, we will contact your insurance company to help determine your level of benefits. Please note that insurance estimates and pre-estimates are not a guarantee from your insurance company.
3. Your insurance policy is a contract between your employer and your employer's insurance company. We are not party to that agreement. Our office cannot accept responsibility for negotiating a settlement with your insurance company on a disputed claim.
4. We generally accept assignment of benefits (payment) from your insurance company, but we reserve the right to refuse assignment. In that case, full payment is due by you at the time of service and your insurance company will reimburse you directly.
5. In the event that you wish to have us invoice your insurance directly, you are agreeing to the following statement: I request the payment of authorized insurance benefits for any services furnished to me be made on my behalf to Dental Care of Northfield.

Payment Policies:
As a condition of your treatment by this office, financial arrangements must be made in advance. We depend upon payment from our patients for the costs incurred in their care and the financial responsibility on the part of each patient must be determined before treatment. We will discuss financial options with you before rendering treatment.

By signing below, you are agreeing to all of the terms contained in this Financial Responsibility Agreement, including the following:

1. Payment is *due in full at time of service* unless prior written financial arrangements have been made.
2. There is a $35 service charge on all returned checks.
3. We reserve the right to charge a missed appointment fee for no-shows or cancellations with less than 24 hours' notice.
4. I understand and agree that any account balance not paid within 90 days will be subject to collection activity. I understand that Dental Care of Northfield may retain the services of an attorney to assist with the collection of any outstanding balance.
5. I understand and agree that I will owe attorney's fees on the unpaid balance owed, plus court costs on any account not paid within 90 days of the last date of service.
6. I understand and agree that, ultimately, I am responsible for payment on my account. As guarantor, I am responsible for any outstanding balances for other family members listed on the same account, due to Dental Care of Northfield.

Print Patient Name: _____ **Signature:** _____

Guarantor Signature: _____ **Date:** ___/___/___

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Payment Options

Dental Care of Northfield strives to offer convenient payment options while at the same time maintaining the high standard of comprehensive dental care that our patients deserve. At the onset of your treatment, we will provide you with an estimate of your total treatment costs. Our goal is to help you afford your dental choices.

Should the need for additional treatment arise during the course of the original treatment plan, the estimated fees could change. Be assured that we will notify you of any fee changes and obtain your approval prior to proceeding with treatment. Please review the financial options offered and indicate your choice of payment.

Plan A: To demonstrate our appreciation to patients who pay in full by Cash or Check prior to or on date of service (fees of $1200 or higher), we will extend a bookkeeping courtesy of five percent (5%).

Plan B: Payment can be made in installments for patients who are established with the practice and have a proven credit history. You can begin your treatment with an initial down payment of 50%. The remaining balance may be divided into 2 or 3 equal monthly payments with no interest.

Plan C: We offer our patients another extended monthly payment plan option through a dental financing company called Care Credit. Please talk to our Financial Coordinator prior to treatment for more details and to receive a credit application.

Plan D: Our goal is to help you maximize your dental insurance benefits. As a courtesy, we will accept the assignment (payment) of insurance benefits, provided we have current credit card information on file to charge any remaining balance not paid by insurance. In some instances, we may request payment of your estimated out-of- pocket expense at the time of service. If your dental insurance does not pay within 60 days of treatment, we will charge the outstanding balance to your credit card, and you must seek reimbursement from your insurance company.

Credit Card #: _____

Exp. Date: _____

Card Holder Signature: _____

Printed Name: _____

Please feel free to discuss any questions you may have regarding the payment options described above with our Financial Coordinator. We thank you for trusting us with your dental care needs.

I,_____, have chosen Plan_____(payment option) and accept full financial responsibility for all services provided to me and/or my dependents in this dental office. I understand that it is up to me to confirm my insurance eligibility, waiting periods, and benefits. I understand that this office cannot guarantee my insurance status in any of these areas. Any insurance estimate given to me by this office is not a guarantee of actual insurance payment. I understand that any insurance claim not paid in full after 60 days becomes my responsibility at that time.

Patient (or Responsible Party) Signature: _____

Dental Care of Northfield Financial Coordinator Signature: _____

DATE:____/____/_____