GRANTSVILLE
FAMILY DENTISTRY
HOLLY E. SISLER, D.D.S.

It is very important that we know the following information about you prior to any treatment.

PATIENT INFORMATION

Name: _____ Sex: M or F

Address: _____

City: _____ State: _____ Zip: _____

Home Phone#: _____ Cell Phone#: _____

Date of Birth: _____ Social Security #: _____

E-Mail Address: _____

EMPLOYER INFORMATION

Employer Name: _____Phone# _____

Address: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Phone#: _____

HEALTH QUESTIONS

1. Is your general health good? Yes or No
2. Do you have a Primary Care Physician? Yes or No
   - If Yes, Physician's Name & Phone Number

   _____
3. Preferred Pharmacy? _____
4. Are you currently taking any medications? Yes or No If Yes, please list

   _____

   _____
5. Are you currently taking any blood thinners? Yes or No If Yes, Please List

   _____
6. Do you currently use Tobacco Products? Yes or No
7. Are you allergic to any medications? Yes or No If Yes, please list

   _____

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7. Do you have, or ever had any of the following:

- ☐ Heart disease
- ☐ Rheumatic fever
- ☐ Heart murmur/mitral prolapse
- ☐ Jaundice
- ☐ Epilepsy
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ High Cholesterol
- ☐ Hepatitis
- ☐ Venereal disease
- ☐ HIV +/AIDS
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Prolonged Bleeding
- ☐ Allergies
- ☐ Tumor or other growth
- ☐ Shortness of breath
- ☐ Diabetes
- ☐ Chest pain on mild exertion
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Ulcer
- ☐ Asthma
- ☐ Cancer
- ☐ Heart Valve Replacement
- ☐ Joint Replacement
  - Body Part(s)_____
  - Date(s)_____
- ☐ Anxiety/Depression
- ☐ Currently Pregnant

8. Any other problems we should be aware of: _____

This information is strictly confidential and will not be released without your permission. The guarantor of this account is responsible for payment in full.

Signature: _____ Date: _____

(Patient, parent or guardian **MUST** sign prior to treatment)

After you review the attached Privacy Policy/HIPAA Compliance please sign below:

Signature: _____Date: _____

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Financial Agreement

We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our Financial Policy, which we require that you read, agree to, and sign prior to any treatment. We are pleased to discuss our professional fees with you at any time. Please ask if you have any questions about our fees, Financial Policy, or your responsibility upon arrival at your first appointment.

ADULT PATIENTS - Adult patients are responsible for full payment at time of service.

MINORS ACCOMPANIED BY AN ADULT - The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

INSURANCE - We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.

Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time. If you are paid by the insurance company instead of our practice, you then become responsible for the total account balance and payment would be expected immediately.

We ask that you sign this form and/or any other necessary documents that may be required by your insurance company.

DEDUCTIBLE/CO-PAYMENT - We may ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, credit card or Patient Financing at the time we provide the service to you.

MEDICARE/ MEDICAID/ CHAMPUS/ WORKER'S COMPENSATION - If you are covered by Medicare, Medicaid, CHAMPUS, Worker's Compensation or any other government sponsored program, please discuss your payment situation with our office staff prior to arriving at the office on the date of service.

DELINQUENT PAYMENTS - It is our policy to charge a finance fee for outstanding patient balances. In addition, all payments returned due to non-sufficient funds will be subject to a fee.

MISSED APPOINTMENTS – We respectfully request at least a 24-hour notice for ALL cancellations. Cancellations/No Shows without a 24-hour notice may result in a fee for missed appointments. **After two failed appointments without a 24-hour cancellation notice the patient may be dismissed from our office.** Please help us service you better by keeping scheduled appointments.

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REFUND POLICY - You may discontinue treatment and request a refund at any time for any amount that you paid for treatment that you did not receive. Please contact our office if you'd like to request a refund.

By signing this agreement, I confirm that I have read, understand and agree to the above terms and conditions. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer.

_____

Patient Name Signature of patient or legal guardian Date