

We Care Dental Care
Benjamin Burkitt D.M.D.

Patient Information

Name _____ Nickname _____

Gender _____ Date of Birth _____

Home Address _____ City _____

State _____ Zip _____ Email _____

Employed by _____

Social Security Number _____

General Health Information

Physician _____ Phone _____

Does our office have your permission to contact your Physician if needed

Yes ___ No ___

Have you ever been hospitalized if so when and for what reason?

For what reason did you schedule this appointment _____

Whom may we thank for referring you? _____

Medical History **Circle all that apply**

Medical Conditions

Anxiety	Mumps	Jaundice
Joint replacement	Cancer	Drug reaction
Diabetes	Cold Sores	Asthma
Immunological Disorder	Kidney	Seizures
Bleeding Disorder	Bladder	Gastro Intestinal

Heart Disease: Rheumatic Congenital Murmur

Allergies

Medications:

List any surgeries you have had:

Do you smoke? Yes No

Are you pregnant or nursing? _____

Patient Signature _____

Date: _____

WE CARE DENTAL CARE FINANCIAL POLICY

Assignment and Release

I the undersigned, have insurance with _____, and assign directly We Care Dental Care all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Date: _____ Signature: _____
Signature of patient/parent/legal guardian

Patient Agreement and Financial Policy

I hereby agree to be responsible for the costs of care provided by We Care Dental Care and/or the dental team for myself or my dependent(s). These include any deductibles and amounts not covered by insurance. **I also understand that it is my responsibility to be aware of any limitations, and benefits of my insurance policy.** Payment to this office is my responsibility and I am aware that if the insurance company does not reimburse the doctor, I am responsible for the total amount(s).

I understand that because appointments are not double-booked, I must provide notice of cancellation at least 48 hours prior to my scheduled appointment time. A \$50 cancellation fee may apply if I do not provide notice of cancellation at least 48 hours prior to my scheduled appointment time.

We make every effort to schedule appointments that are most convenient for you and that fit your personal schedule. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. In return, we ask that you make every effort not to change your reserved dental appointment.

I understand that payment in full is due at the time of service. I understand that after 90 days, any unpaid balance will incur a \$30 billing fee. I understand that failure to pay amounts due to this office will result in my account being placed with a collection agency. In the event that my account is further referred to an attorney, I agree to pay all collection and attorney fees.

Date: _____ Signature: _____
Signature of patient/parent/legal guardian

We Care Dental Care
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 We Care Dental Care. I hereby authorize, as indicated by my signature below, We Care Dental Care 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

Address

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 may send me an unencrypted email/text message 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) _____