Welcome!

We are delighted to welcome you to our practice. Please answer the following few questions so that we may better address your oral health needs.

Name:_____

Reason for today's visit:_____

_____

Are you in any pain? _____

_____

Are you concerned about anything regarding your teeth, gums, or general oral health?

_____

_____

Is there anything you would like to change about your smile?

_____

_____

Suzanne G. Boyle, DMD, LLC

Patient Information:

Name: (last)_____

(first)_____ (middle initial) _____

Address: _____

City: _____ State:_____ Zip:_____

Email:_____

Date of Birth: _____Gender: (M)_____ (F)_____ Age: _____

Patient Employer/School _____

Occupation _____Soc Sec #_____

Spouse's Name _____

Phone number: (home)_____ (work)_____

(cell)_____ Please indicate which number is preferred

IN CASE OF EMERGENCY, CONTACT (Please specify someone who does not live in your household)

Name:_____

Relationship:_____Phone:_____

Dental Insurance:

Who is responsible for this account?

Name:_____ Relationship to patient_____
Dental
InsuranceCo:_____Group#_____

Subscriber's Name:_____ Member ID#_____

Date of Birth:_____ Relationship to patient_____

Is patient covered by secondary dental insurance? If so, please specify insurance company, group number and member ID

_____

ASSIGNMENT AND RELEASE:

I certify that I, and/or my dependent(s), have dental insurance coverage with

(name of company)_____, and assign directly to Suzanne G. Boyle, DMD all insurance 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 my insurance carrier. I authorize the use of my signature on all insurance submissions.
The office of Suzanne G. Boyle, DMD may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____
(Signature of patient, parent, guardian or personal representative)

Please print_____ Date_____

Health Information and History:

Patient's Name:_____ Date of birth_____

Primary Physician:_____

Other Physicians and Specialists:_____

_____

_____

Within the last three years, have you been hospitalized or had surgery?_____

Have you ever been instructed to take ANY medications or take ANY special precautions before any dental appointments?_____

_____

Are you taking any prescription drugs, medications or treatments at this time? Any over-the-counter medications, vitamins, supplements? Have you ever taken bisphosphonates (Fosamax, etc)? If you have a complete written list, please give that to us instead.

_____

_____

Have you ever had chemotherapy or radiation treatments? _____

Are you allergic to or have you ever had any reaction to any:

___Latex	**___Metals or jewelry**	**___Dental anesthesia (local)**
___Fluoride	**___General anesthesia**	**___Nitrous oxide (laughing gas)**
___Penicillin (or related)	**___Aspirin/ibuprofen/NSAID**	**___Codeine**
___Tranquilizers (valium)	**___Keflex(cephalexin)**	**___Clindamycin(Cleocin)**
___Tetracycline	**___Sulfa drugs**	**___Erythromycin**

Anything else not named above?_____

_____

Name_____ (continued):

Do you have, or have you ever had, any of the following?

	Yes	No		Yes	No
Congenital heart defects	___	___	Asthma	___	___
Angina or chest pains	___	___	Hay fever, skin or food allergies	___	___
Atherosclerosis	___	___	Sinus problems	___	___
Congestive heart failure	___	___	Tuberculosis, emphysema or lung disorder	___	___
Coronary artery disease	___	___			
Heart surgery	___	___	Skin problems	___	___
Heart attack	___	___	Sore or wound that bleeds easily or does not heal	___	___
Rheumatic heart disease	___	___			
Infective endocarditis	___	___	Thyroid problem or disease	___	___
Heart valve damage	___	___	Arthritis	___	___
Mitral valve prolapse	___	___	Glaucoma or any eye disease	___	___
Artificial heart valve	___	___	Epilepsy or seizure disorder	___	___
Pacemaker	___	___	Kidney problems	___	___
Stroke or CVA	___	___	Ulcers, acid reflux, or stomach problems	___	___
High blood pressure	___	___			
Low blood pressure	___	___	Compromised immune system (Lupus, HIV/AIDS, radiation/ chemo immune problem etc	___	___
Anemia	___	___			
Hemophilia or bleeding disorder	___	___	Active sexually transmitted disease (STD)	___	___
Excessive bleeding from any cut	___	___	Mental health issues	___	___
Diabetes/blood sugar problems	___	___	Psychiatric condition	___	___
Artificial joint, joint surgery, Or prosthesis	___	___	WOMEN ONLY:		
Hepatitis, jaundice, or other Liver problems	___	___	Are you pregnant?	___	___
			Possibly pregnant?	___	___
Any form of cancer	___	___	Presently nursing?	___	___
An organ transplant	___	___	Using birth control?	___	___
			Hormone replacement therapy?	___	___

ANY other information of which we should be made aware?_____

CONSENT—To the best of my knowledge, all of the preceding information is correct, and if there is ever any change in health, or medications, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis and treatment to be performed by this practice for the above-named individual until further notice. I understand there are no guarantees or warranties in health or dental care.

Signature:_____ Date: _____

Our Financial Policy:

Thank you for choosing the office of Suzanne G. Boyle, DMD, LLC as your dental care provider. We are very committed to giving you the highest quality of care. We will strive to make your visit a pleasant experience. Please tell us if there is anything that we can do to make you more comfortable during your visit. We have a highly trained staff who is eager to assist you with all of your dental needs.

Method of Payment:
We accept checks, cash, all major credit cards and Care Credit.

Insurance and Benefits Collection:
Please understand that insurance reimbursement can be a long and difficult process for parties involved. To that end, our staff has undergone extensive training to reduce the time involved in satisfying claim payments. However, this depends primarily upon your providing our office with complete and accurate insurance information. This includes the subscriber's name, date of birth, group number, member ID number, name of insurance company along with the correct claim submission address. Although, we carefully respect our patients' privacy, there are some insurance companies that still require the subscriber's social security number in order to process claims. We DO NOT require our patients to supply their social security numbers, however, should a claim be denied due to lack of information supplied by us, it will be necessary to transfer the balance due to your account. Your insurance coverage is an agreement between you and the insurance carrier. Any claim that has not been paid in a reasonable amount of time will have the balance transferred to your account. Please realize that should this become necessary, our staff will have already made several attempts to have the claim satisfied. You are responsible for any and all balances due to this office regardless of insurance coverage.

Copays and Deductibles:
All copayments are due at the time of service. Insurance plans may cover procedures at a varying percentage or apply a deductible to any visit they choose. It is due to this fact that we collect an ESTIMATED amount. It is possible, after paying a co-payment, and your insurance company paying their portion, that you may still have a balance with this office. We strongly recommend that you

familiarize yourself with your coverage. Feel free to ask any questions regarding your explanation of benefits that you may receive from your insurance carrier as well as with any statements you receive from this office.

Divorce Decrees:
This office is NOT party to your divorce decree. We will gladly submit claims for minors, but any co-payment is due at the time of service and must be paid by the accompanying adult.

Alternate Benefit Provision:
Some insurance plans will only cover a less expensive, but adequate procedure. The most common examples of this include: silver vs tooth-colored fillings, metal vs tooth-colored crowns ("caps"). If you choose the more expensive option, there will be a modest balance due that will be your responsibility. We have seen this to be a changing variable even in long-held insurance plans. We will gladly pre-authorize any procedure you choose with your insurance carrier, but please be aware that this typically adds at least 30 days to the treatment process.

Assignment of Benefits:
I, the undersigned, hereby authorize and assign payment of dental benefits by my insurance company to Suzanne G. Boyle, DMD, LLC for services rendered.

Third Party Collections:
I, the undersigned understand that I am financially responsible for professional fees, including those not paid by my insurance company. If, upon default, this matter is referred to a third party collection agent, I agree that 33% shall be added to the delinquent balance at the time of referral. I agree that this percentage and the resulting balance are considered to be reasonable.

The undersigned certifies that he/she has read and understands this document and is the patient or parent/guardian of the patient, or is duly authorized to accept its terms.

Patient/Parent:_____Date:_____

Witness:_____
_____