CONFIDENTIAL PATIENT INFORMATION

NAME: (First)_____(MI)____(Last)_____(Preferred)_____

ADDRESS:_____CITY:_____STATE:_____ZIP CODE:_____

PHONE: (cell)_____(home)_____(work)_____

NAME OF WORKPLACE:_____

EMAIL ADDRESS:_____

BIRTH DATE:_____SSN: _____ [ ]MALE [ ]FEMALE

MARITAL STATUS: [ ]MARRIED [ ]SINGLE [ ]DIVORCED [ ]WIDOWED [ ]OTHER

IF MARRIED, SPOUSES NAME:_____SSN:_____BIRTHDATE:_____

RESPONSIBLE PARTY (MUST HAVE SIGNATURE ON THIS FORM)

PERSON RESPONSIBLE FOR THIS ACCOUNT: (First)_____(Last)_____

RELATIONSHIP TO THE PATIENT:_____

ADDRESS:_____CITY:_____ZIP CODE:_____

PHONE:_____SSN:_____BIRTHDATE:_____

DENTAL INSURANCE INFORMATION

POLICY HOLDER'S NAME: (First)_____(Last)_____SSN:_____

BIRTHDATE:_____EMPLOYER:_____EMPLOYER'S PHONE:_____

DENTAL INSURANCE COMPANY NAME:_____ADDRESS:_____

INSURANCE PHONE:_____GROUP NUMBER:_____

RELATIONSHIP TO PATIENT:_____

I AUTHORIZE PAYMENT OF DENTAL BENEFITS TO BE PAID DIRECTLY TO THE PROVIDER.

SIGNATURE:_____DATE:_____

MEDICAL HISTORY

If yes, please list:

Are you under a physician's care now? [ ]Y [ ]N_____

Have you ever been hospitalized or had a major operation? [ ]Y [ ]N_____

Are you taking any medication, pills, or drugs? [ ]Y [ ]N_____

Do you use controlled substances? [ ]Y [ ]N_____

Do you use tobacco? [ ]Y [ ]N_____

Women: Are you: __Pregnant/Trying __Nursing __Taking Contraceptives

Are you allergic to any of the following: __Aspirin__Penicillin__Codeine__Acrylic__Metal__Latex

__Local Anesthetics__Amoxicillin__Sulfa__Other (please list)_____

Do you have or ever had any of the following:

__AIDS/HIV Positive	__Emphysema	__Hives or Rash	__Stroke
__Alzheimers Disease	__Epilepsy/Seizures	__Hypoglycemia	__Swelling
__Anemia	__Excessive Bleeding	__Kidney Disease	__Thyroid Disease
__Arthritis/Gout	__Fainting/Dizziness	__Leukemia	__Tonsilitis
__Artificial Heart Valve**	__Frequent Headaches	__Liver Disease	__Tuberculosis
__Artificial Joints**	__Herpes Simplex	__Low Blood Pressure	__Tumors
__Asthma	__Glaucoma	__Lung Disease	__Ulcers
__Blood Disease	__Hay Fever/Allergies	__Mitral Valve Prolapse**	
__Blood Transfusion	__Heart Attack/Failure	__Rheumatic Fever**	
__Cancer	__Heart Disease	__Scarlet Fever	
__Chemotherapy	__Heart Murmur	__Shingles	
__Cold sores/Fever Blisters	__Hemophilia	__Sickle Cell Disease	
__Congenital Heart Disorder	__Hepatitis A, B, or C	__Sinus Problems	
__Diabetes	__High Blood Pressure	__Spina Bifida	

Have you ever had any serious illness not listed? [ ]Y [ ]N

Comments:_____

Patient Dental History:

Do your gums bleed while brushing or flossing?	[ ]Y [ ]N	Do you wear dentures or a partial?	[ ]Y [ ]N
Do you clench or grind your teeth?	[ ]Y [ ]N	Would you like your teeth to look whiter?	[ ]Y [ ]N
Are your teeth sensitive to hot/cold liquids or food?	[ ]Y [ ]N	Do you like your smile?	[ ]Y [ ]N
Do you feel pain in any of your teeth?	[ ]Y [ ]N	Have you had any orthodontic treatment?	[ ]Y [ ]N
Have you had any head, neck, or jaw injuries?	[ ]Y [ ]N	Do you have frequent headaches?	[ ]Y [ ]N
Prolonged bleeding after extractions?	[ ]Y [ ]N		

Do you have any of the following in your jaw: circle: Clicking - Pain (joint, ear, face) - Difficulty chewing

Authorization and Consent:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I give consent to be seen by the doctor and if I elect treatment, I consent for the work to be done and understand that during the coruse of the procedures unforeseen conditions may occur which necessitate procedures other than contemplated. I am aware there may be additional charges. If a collection problem arises, I understand that I am responsible for all collection fees including attorney fees, court costs, and late charges.

HIPAA:

I have received and acknowledged the Notice of Privacy Practices and consent for use and disclosure of health information. I give this practice consent to use or disclose my health information to carry out treatment, obtain insurance payments, and health care operations.

Signature of patient/legal guardian:_____Date:_____

OUR FINANCIAL POLICY

Dr. ROLANDO R. PAPAGAYO D.D.S., P.C.

640 W. REPUBLIC RD. SUITE 124

SPRINGFIELD, MO 65807

GENERAL:

Thank you for choosing our practice as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of a contract. All patients must complete our information and insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, MONEY ORDER, VISA, MASTERCARD, DISCOVER CARD, AMERICAN EXPRESS, AND CARE CREDIT.

INSRANCE:

If we are unable to verify your dental insurance coverage, you will be responsible for the entire balance on your account. YOU ARE EXPECTED TO PAY YOUR ANNUAL DEDUCTIBLE AND ESTIMATED PATIENT PORTION ON THE DATE OF SERVICE. We file insurance as a courtesy to you. You are responsible to know your own policy. We can estimate what your insurance is expected to pay by the basic information they provide our office. You will receive a bill for an amount not covered by your insurance. Any unpaid amounts are your responsibility. If you believe that insurance should have paid, (or paid more) it is your responsibility to contact your insurance company to question the amount paid.

REGARDING TREATMENT PLANS:

Fees and estimates are valid for one year from the date shown on your signed treatment plan but, are subject to revision (i.e. such as a change in your insurance carrier or termination of coverage). Treatment could be altered if your dental needs change. The patient will be notified of any changes in treatment.

MINOR PATIENTS:

The adult accompanying a minor (legal guardian) is responsible for full payment. Unaccompanied minors can only be seen for non-invasive procedures. For all invasive procedures, parent or legal guardian must be present in our office throughout the procedure.

MISSED APPOINTMENTS AND CANCELLATIONS:

Our policy is to charge for missed appointments and last minute cancellations (less than 24 hours) at the rate of $50.00. Due to Saturday appointments being high in demand, if you miss or cancel a Saturday appointment with less than 24 hours notice, you will no longer be able to schedule for any future Saturday appointment. Please help us serve you by keeping your scheduled appointments.

CONSENT:

I understand and agree to the terms of this policy.

Signature:_____Date:_____