STEVEN P. RAFEEDIE, D.M.D.

Thank you for selecting us as your personal dental care team. To promote a long-term mutually satisfying relationship, we would like to explain our office policy regarding treatment, insurance, appointments and fees. PLEASE, read this carefully and ask any questions or bring up any concerns you may have BEFORE treatment is rendered. SUBMISSION TO TREATMENT IMPLIES YOUR CONSENT TO THE TERMS OF THIS AGREEMENT.

TREATMENT: You will find out entire staff is dedicated to helping you improve your dental health as quickly as possible. Every effort will be made to make your appointment as comfortable and pleasant as possible. Please feel free to discuss your treatment with the doctor at any time.

INSURANCE: If this office is able to accept your insurance company's assignment, the patient is still FULLY RESPONSIBLE for the charges for treatment rendered. Your insurance MAY NOT COVER the services or may only PARTIALLY cover them and any ESTIMATE given by this office is considered a GUIDELINE until the final insurance is received and the patient's account is reconciled. The office can make NO GUARANTEE of the actual payment by your insurance company.________Initials

MISSED APPOINTMENTS: When we schedule your appointment, the time is reserved exclusively for you. When you fail to notify us of your inability to keep an appointment, another patient in need of dentistry is unable to receive treatment. We request that you give us at least 24 hours notice when you realize that you cannot keep an appointment. When the requested notice is not given, a fee of $55.00 will be charged to your account. For those whose schedules make it difficult to effectively plan ahead, we ask that you do not schedule an appointment in advance, but that you call us the day you can come in and we will be happy to see you then - provided the time is available.

PAYMENT IS DUE AT THE TIME OF SERVICES: We accept cash, personal checks, and all major credit cards. When insurance applies, we will collect any deductible and estimated co-pay at this time.

We have two payment options available for patients needing extensive dental work. Both must be Approved before services are rendered. Please ask receptionist for more information if interested.

Prosthetics, Crowns, Dentures, Bridge, Etc. FAILURE BY MEMBER TO RETURN FOR THE DELIVERY OF THESE ITEMS IS SUBJECT TO DOCTOR TIME AND LAB FEES CHARGES. ________Initials

SERVICE CHARGES:

1. MONTHLY BILLING: Even though an insurance claim has been filed, you will receive a statement each month if there is a balance due on your account, since you, not the insurance company, are responsible for payment of your account. A 25.00 charge will be applied every month to accounts with balances outstanding 60 days or longer, regardless of outstanding insurance.

2. RETURNED CHECKS: There is a $25.00 fee for returned checks. The check must be picked up personally and cash must be paid to cover the check and the fee.

3. COLLECTION FEES: Fees incurred to enforce payment required by this agreement will be charged to the patient whose failure to pay, required these fees to be incurred.

Signature:____ Date:____________________
Patient/Parent or Legal Guardian if patient is a minor

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Welcome to our office. We will do our best to make your appointment as convenient and pleasant as possible. If at any time you have any questions regarding your treatment, appointments, or fees, please feel free to ask. Your kindness in furnishing the following information will be appreciated and will be used in strict confidence to prepare your clinical chart.

Today's Date ____________

Patient Name ______________________ Preferred Nick Name ______________

Social Security No. ______________________ Date of Birth ______________

Address ______________________ Apt. No. ____________

City, State, Zip ______________________

Home Phone ____________ Work Phone ____________ Cell ____________

Employer ______________________ E-mail ______________________

Preferred Contact Method: Call / Text / E-mail

Spouse's Name ______________________ Social Security Number ______________

Employer ______________________ Date of Birth ______________

Employer's Address ______________________

Work Phone ______________________ Cell ______________________

____

Referred By: ____

If Patient is a child, Who will be responsible for bill?

Name ______________________ Preferred Nick Name ______________

Social Security No. ______________________ Date of Birth ______________

Address ______________________ Apt. No. ____________

City, State, Zip ______________________

Home Phone ____________ Work Phone ____________ Cell ____________

Employer ______________________ E-mail ______________________

Preferred Contact Method: Call / Text / E-mail

Insurance Information

Do You Have Insurance Coverage? ________ Your Own? ________ Spouses? ________ Both? ________

Carrier: ______________________ Group No. ______________ Primary / Secondary

If dual coverage, please indicate spouse's

Carrier: ______________________ Group No. ______________ Primary / Secondary

Payment

Please Indicate The Payment Method You Find Most Convenient.

1. _______ Payment in full at time of treatment (Cash/Check/Credit Card)
2. _______ Insurance (your deductible and estimated portion due at time of treatment)
3. _______ Outside financing available. (subject to approval)

As a courtesy, we will file your dental insurance, but we request that you pay your estimated portion when services are rendered. All balances are due within 60 days, including outstanding insurance claims. All balances not taken care of *after 60 days will* be charged a late fee of $25.00 per month. Returned check fee is $25.00. Kindly give us 24 Hours notice if you need to change your appointment. Last minute cancellations and broken appointments will be subject to a charge to cover the time reserved for the *appointment*.

Patient/Parent Signature ______________________________

Medical History on Back

Medical History

Today's Date ____________

Patient's Name ______________________________ Name Called ______________

Physician's Name & Telephone No. ______________________________________

Person to call in event of emergency ____________________________ Phone ____________

Are you presently undergoing treatment for a specific problem? ________ If so, what? ______________

____

____

____

Please list all medications you are presently taking: ______________________________

____

____

____

Have you had any serious illnesses or operations? Yes No

If yes, please explain. ____

____

Are you allergic to any of the following? (Circle all that apply)

Penicillin Sulfur Codeine Aspirin Local Anesthetic Latex Other ____________

Has it ever been recommended that you take an antibiotic prior to a dental appointment? Yes No

If yes, please explain. ____

Have you ever had any of the following conditions? (Circle all that apply)

Excessive Bleeding	Rheumatic Fever	Kidney Disease	Hives
Heart Attack	High Blood Pressure	Cancer	Infectious Disease
Arrhythmia	Stroke	Thyroid Disease	HIV
Angina	Dizziness	Hepatitis	Osteoporosis
Artificial Heart Valve	Fainting	Liver Disease	Sinus Problems
Artificial Joints	Convulsions	Asthma	Mitral valve prolapse
Heart Murmur	Diabetes	Allergies	Tobacco Use

Are You Pregnant? __________ If so, due date ______________________________

Other Medical Conditions? ____

____

____

Do you consider yourself in good health? ______________________________

Patient's / Parent's Signature ______________________________________