Come Smile with Us

Date: _____

Name_____ Nickname: _____
Last First

Home (_____) _____ Cell (_____) _____Work (____) _____

Please circle the best way to contact you: Home Work Cell Email Text Message

Email _____ S.S#_____

Address_____ City _____ Zip _____

Sex: M F Age _____ Birthdate_____ Marital Status: S M D W

Patient Employer/School_____ Occupation_____

In case if emergency who should be notified? _____Phone (_____) _____

Whom may we thank for referring you: _____

Responsible Party

Person Responsible for this Account _____

Relation to Patient_____ Birthdate _____S.S. #_____

Insurance

Primary Insured for Account_____Id#_____

Insurance Company_____ Group#_____

Dental History

Reason for Today's Visit _____ Date of last dental care _____
Former Dentist _____ Date of last dental X-rays _____
Address_____

Circle if you have had problems with any of the following:

Bad Breath	Grinding teeth	Sensitivity to hot
Bleeding gums	Loose teeth or broken fillings	Sensitivity to sweets
Clicking or popping jaw	Periodontal treatment	Sensitivity when biting
Food collection between teeth	Sensitivity to cold	Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

How do you feel about your smile? _____

Medical History

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? Y or N If yes, describe_____

(Women) Are you pregnant? Y or N Nursing? Y or N Taking birth control pills? Y or N

Your health is important to us. Please **circle** if you have had:

Anemia	Cough, Persistent	Hemophilia	Scarlet Fever
Arthritis, Rheumatism	Cough up Blood	Hepatitis (A, B. or C)	Shortness of Breath
Artificial Heart Valves	Diabetes	High Blood Pressure	Skin Rash
Artificial Joints	Dry Mouth	HIV/AIDS	Sleep Apnea
Asthma	Eating Disorder	Jaw Pain	Stroke
Back Problems	Epilepsy	Kidney Disease	Swelling of Feet/ Ankles
Blood Disease	Fainting	Liver Disease	Thyroid Problems
Cancer	Gastric Reflux	Mitral Valve Prolapse	Tobacco Habit
Chemical Dependency	Glaucoma	Pacemaker	Tonsillitis
Chemotherapy	Headaches	Radiation Treatment	Tuberculosis
Circulatory Problems	Heart Murmur	Respiratory Disease	Ulcer
Cortisone Treatment	Heart Problems	Rheumatic Fever	Venereal Disease

Do you have any medical condition not mentioned above? _____

Do you take/or have you taken Bisphosphonate drugs for osteoporosis? _____

List any **medications** currently taking and the correlating diagnosis: _____
_____

Allergies (Circle all that apply):

Aspirin	Latex
Barbiturates	Penicillin
Codeine	Sedatives
Dental Anesthetics	Sulfa Drugs
Erythromycin	Tetracycline
Jewelry/Metals	No known allergies

Other: _____

Microsoft Office Outlook 2003.lnk

Pharmacy Name: _____ Phone # _____

Patient's signature _____ Date _____

ACKNOWLEDGEMENT
Of Receipt of
PRIVACY PRACTICES

Dr. Roseanne Ganley, D.D.S.

You May Refuse to Sign This Acknowledgment

I have received a copy of this office's Notice of Privacy Practices.

Patient Name: _____

Guardian / Legal Representative: _____
(if patient is minor or unable to sign)

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please specify)

_____

_____

_____

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Roseanne Ganley D.D.S.

Welcome to our practice! We are happy you have chosen us for your dental care. In order to better serve you, please read the following summary of our financial policy. If you have any questions, please ask one of our friendly and knowledgeable team members. We are here for you.

Payment Options

We recognize that patients have financial needs and we will make every effort to find a solution that works best for you. Dr. Roseanne Ganley accepts Cash, Visa, MasterCard, Discover, American Express and personal checks. Also, CareCredit interest free financing is available upon approval. Please see the CareCredit website for information and to complete an application.

If your check is dishonored or returned by your bank for any reason, you will be charged a returned check fee of **$25.00** and your checks will no longer be accepted. _____ **(Initials)**

Insurance

You are responsible for all charges regardless of insurance coverage. As a courtesy, we are happy to file claims with your primary insurance company for services rendered. Your deductible and/or co-insurance are due at the time services are rendered. However, if we have not received payment from your insurance company within 60 days from the date of the service, you will be expected to pay the balance in full. We will do everything to determine an accurate estimate of your coverage, **but our estimate for your treatment is only that: an Estimate**. Please be aware that some, and perhaps all, of the services provided may not be covered under your insurance policy. We will not become involved in disputes between you and your insurance company regarding coverage and/or policy benefit criteria, i.e. deductibles, non-covered services, co-insurance, coordination of benefits or "reasonable and customary charges." Your account balance is a contract between you and Roseanne Ganley, D.D.S..; not between your insurance carrier and Roseanne Ganley, D.D.S. **A late fee of $25.00** may be assessed to accounts with balances outstanding for 60 days from treatment date. In the event of non-payment, the responsible party agrees to pay all the costs of collection including, but not limited to attorney fees, court cost, collection agency fees, etc. _____ **(Initials)**

Missed Appointments/Late Cancellations

Your appointment is time that we reserve especially for you. As a courtesy to other patients that could use that appointment time, please call our office at least one business day in advance of your appointment if you must cancel or reschedule. No charge will be made for rescheduling an appointment, provided 24 hours notice is given. **A $55.00 fee will be assessed for any appointment that is missed without a courtesy call to reschedule**. This fee is not payable by your insurance company and will be your responsibility. *Patients with multiple cancellations without notice must make special arrangements to schedule future appointments.* _____ (Initials)

Authorization

I certify that I, and/or my dependents(s), have insurance coverage with _____
Name of insurance Company
and assign directly to Dr. Roseanne Ganley 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 insurance. I authorize the use of my signature on all insurance submissions. I also agree that should it become necessary to forward my account for collection proceedings, in addition to the amount owed, I will also be responsible for the fees associated with the costs of collection.

_____ _____
Signature of Patient, Parent, or Guardian Date

_____ _____
Please print name of Patient, Parent, or Guardian Relationship to Patient