ABOUT YOU

Today's Date: ____/_____/_____

Patient's Name: _____

□Male Female Driver's License#_____

Birthdate: ___/___/___ Age: ___ SS# _____

E-mail Address: _____

Mailing address: _____

_____

Cell Phone: (____) _____

Referred By: _____

Pharmacy Preferred: _____

Pharmacy location: _____

Emergency Contact: _____

Emergency Contact Phone #:_____

More About You

When was your last dental visit? _____

What is the name of your last dentist or practice?

_____

Do you know when your last set of x-rays was taken?

_____

Are you interested in changing your smile? Y/N
Explain:_____

Do you have any concerns about your oral health? Y/N
Explain:_____

Have you had implants placed? Y/N
If yes, Who placed it/them and When?

_____

_____

Are you interested in a sleep apnea device? Y/N

Are you interested in migraine therapy? Y/N

Have you ever experienced TMJ pain? Y/N

Dan K. Dube, D.M.D.
General & Reconstructive Dentistry
5653 Carolina Beach Road, Suite C-1
Wilmington, NC 28412
910.791.0986 ph 910.791.2902 fax

INSURANCE INFO

Please show your insurance cards at time of check-in
Primary Dental Insurance Co.:_____

Member ID: _____

Group # (Plan, Local, or Policy #): _____

Insured's Employer: _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's SS/ID #: _____

Do you have a Second Insurance plan? Y/ N

_____ I hereby authorize assignment of my insurance
Initials rights & benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

Office Policies

- To reduce our administrative costs and keep our fees as low as possible, we ask that you pay your estimated cost at the time of service.
- If the account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. We require 48 hours notice for all rescheduled or cancelled appointments. Failure to do so may result in a $50 fee.
- I have read & understand the privacy policy. I authorize the staff to perform any necessary services needed during diagnosis & treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Print Name: _____

Signature: _____

PLEASE CONTINUE TO THE NEXT PAGE

WHAT'S NEW

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ABOUT YOU

Today's Date: ____/_____/_____

Patient's Name: _____

SS #: _____-____-_____ Birthday: _____

Mailing address: _____ _____

_____

Cell Ph:(____) _____

E-mail Address: _____

In the event of an emergency, whom should we contact? _____

Phone #: _____

INSURANCE INFO

Has any of your Insurance Information changed? Y/N

Co. Name: _____

Member ID#: _____

Insured's Name: _____

Insured's SS # _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

*****Please provide any new Ins. Cards******

PLEASE LIST ALL MEDICATION CURRENTLY TAKING:

ALLERGIES, MEDICATION, DOSE & REASON: *****Use the back of page if more space is needed.*****

_____

_____

_____

_____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N ADHD/ADD
Y N Alzheimer's
Y N Anemia
Y N Angina
Y N Arthritis
Y N Artificial Heart Valves
Y N Artificial Joints
Y N Ascites
Y N Asthma
Y N A-Fib
Y N Back Problems
Y N Barrett's Esophagus
Y N Bleeding Problems
Y N Blood Disorder
Y N COPD
Y N Cancer/Tumor
Y N Celiac Disease
Y N Cerebral Palsy
Y N Chemical Dependency
Y N Chemotherapy
Y N Chronic Inflammation
Y N Chronic Pain
Y N Congestive Heart Failure
Y N Cometic Surgery
Y N Diabetic
Y N Dialysis
Y N Dizziness
Y N Epilepsy/Seizures
Y N Fainting
Y N Fibromyalgia
Y N Frequent Neck Pain
Y N GERD
Y N Gastric Bypass
Y N HIV+ / AIDS / ARC
Y N Hearing loss
Y N Heart Attack
Y N Heart Disease
Y N Heart Murmur
Y N Heart Surgery
Y N Hepatitis (A,B,C)
Y N High Cholesterol
Y N High/Low Blood Pressure
Y N Jaw Pain/TMJ/TMD
Y N Kidney Problems
Y N Leukemia
Y N Liver Disease
Y N Lupis
Y N Mental Disorder
Y N Migraines
Y N Mitro valve Prolapse
Y N Multiple Sclerosis
Y N Nervousness
Y N Osteoporosis
Y N PTSD
Y N Pacemaker
Y N Paralysis
Y N Parkinson's Disease
Y N Pre-Diabetic
Y N Pregnancy
Y N Prostate Conditions
Y N Psoriasis
Y N Psoriatic Arthritis
Y N Radiation Treatment
Y N Red Dye Allergy
Y N Respiratory Conditions
Y N Rheumatic Fever
Y N Scarlette Fever
Y N Severe Frequent Headaches
Y N Shingles
Y N Sinus Problems
Y N Sleep Apnea
Y N Smoker
Y N Stroke
Y N Tuberculosis
Y N Ulcers/Stomach Problems
Y N Venereal Disease
Y N Vertigo
Y N **Dementia (or a Version of it)
Y N **Trying to Conceive
Y N **IVF
Y N **IV Medications for Osteoporosis
Y N **Bisphosphonates
Y N **Blood Thinners
Y N OTHER_____

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Signature _____ Date _____

Dan K. Dube, D.M.D.

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dandubedentistry.com
FINANCIAL AGREEMENT

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employer, and the insurance company. Our practice is not a party to that agreement. *If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.*

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our practice by signing the authorization on the Assignment of Benefits Agreement. In order for our practice to file your insurance claim, you must bring proof of insurance to each appointment.

Your **estimated** copayment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. Your **estimated** copayment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. Our practice accepts cash, personal checks, MasterCard, Visa, American Express, and Discover. Third party, extended payment financing is available upon your request and approval through Springleaf Financial and CareCredit.

Returned checks and balances older than 60 days will be subject to collection fees (30% of balance) and finance charges at the rate of 1.5% per month (18% annually).

*A scheduled appointment is a commitment of time between you and our practice. We have reserved that time **just for you.** When appointments are missed or cancelled, that is time permanently lost. Therefore, our practice will charge $50 for appointments that you do not keep and for appointments that you do not cancel with a **48-hour notice**.*

_____ _____

Printed Name & Signature of Patient or Responsible Party Date

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