

FINANCIAL POLICY

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In our office, you have a variety of financial options from which to choose.

The office accepts the following forms of payment:

- Cash
- Personal Checks
- Debit Cards
- Major Credit Cards

Payment in full is due at the time of service unless other arrangements have been made in advance.

The following payment options are also available to you:

- A. In cases requiring laboratory work, it may be possible to pay for treatment with 50% due on the day of initial treatment and the balance paid in one or two subsequent payments. The Office Manager will discuss these payment options with you.
- B. For patients who wish to pay for treatment over an extended period of time, we offer a payment plan that is administered by an independent company. The Office Manager will provide you with all of the details.
- C. Many of our patients request our assistance in the filing of insurance claims. We are pleased to provide this service. However, we are not a preferred provider for any insurance company or a participant in any network. Our office does not accept assignment of insurance benefits. In other words, we do not accept partial payment for treatment and have the insurance reimbursement check sent to our office. The contract is between the patient and the insurance company, not between the dentist and the insurance company. For this reason, the insurance company is more responsive to the patient than to the treating dentist. Insurance payments directly to the patient are made much more promptly, generally 2-3 weeks. If the patient makes payment by credit card, the insurance check is commonly received by the patient prior to the credit card billing cycle.

Signature

Date

PATIENT'S NAME _____

WHY HAVE YOU COME TO SEE US TODAY? _____

WHEN WAS YOUR LAST DENTAL VISIT? _____ WHAT WAS DONE THEN? _____

PREVIOUS DENTIST (NAME AND LOCATION) (OPTIONAL) _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN? WHEN, WHERE _____

HOW OFTEN DO YOU BRUSH YOUR TEETH? _____ HOW OFTEN DO YOU FLOSS YOUR TEETH? _____

PLEASE CHECK ONE BOX

	YES	NO		YES	NO
DO YOUR GUMS BLEED WHILE YOU ARE BRUSHING OR FLOSSING?	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU HAVE FREQUENT HEADACHES?	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU CLENCH OR GRIND YOUR TEETH?	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	<input type="checkbox"/>	<input type="checkbox"/>	DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)?	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU WORN A BITE PLATE OR OTHER APPLIANCE?	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?			HAVE YOU HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	<input type="checkbox"/>	<input type="checkbox"/>
CLICKING	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	<input type="checkbox"/>	<input type="checkbox"/>
PAIN (JOINT, EAR, SIDE OF FACE)	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU WEAR DENTURES OR PARTIALS?	<input type="checkbox"/>	<input type="checkbox"/>
DIFFICULTY IN OPENING OR CLOSING	<input type="checkbox"/>	<input type="checkbox"/>	IF YES, DATE OF PLACEMENT _____		
DIFFICULTY IN CHEWING	<input type="checkbox"/>	<input type="checkbox"/>			

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? _____

NOTES: _____

PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ DATE _____
FIRST MI LAST

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SOC. SEC. # _____ BIRTHDATE _____ HOME PHONE _____

WORK PHONE _____ CELL PHONE _____ PAGER # _____

EMAIL ADDRESS _____

SPOUSE OR PARENT'S NAME _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

CHILDREN INFORMATION

NAME	BIRTHDATE	NAME	BIRTHDATE
NAME	BIRTHDATE	NAME	BIRTHDATE

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

SOC. SEC. # _____ DRIVER'S LICENSE # _____ BIRTHDATE _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES NO

DENTAL INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____

NAME OF EMPLOYER _____

INSURANCE CO. _____ GRP # _____ POLICY / I.D. # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

INS. CO. PHONE # _____

ALL SERVICES ARE TO BE PAID IN FULL AT THE TIME OF SERVICE UNLESS PREVIOUS ARRANGEMENTS ARE MADE.

I GIVE PERMISSION FOR ANY PHOTOGRAPHS TAKEN OF ME TO BE USED IN PROFESSIONAL PRESENTATIONS OR JOURNALS.

I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION, INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME DURING THE PERIOD OF SUCH DENTAL CARE, TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS.

I HAVE RECEIVED AND WILL/HAVE REVIEWED THIS OFFICE'S PRIVACY POLICY.

Signature of Patient or Parent If Minor

Date

Patient Information

PATIENT'S NAME _____ DATE _____

		YES	NO			YES	NO
1. ARE YOU IN GOOD HEALTH?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. HAVE YOU HAD A RECENT WEIGHT LOSS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. DATE OF YOUR LAST PHYSICAL EXAM: _____				10. HAVE YOU EVER TAKEN FEN-PHEN OR REDUX?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. PHYSICIAN'S NAME _____ ADDRESS _____ PHONE NO. _____				11. DO YOU USE TOBACCO?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PLEASE EXPLAIN. _____				13. ARE YOU WEARING CONTACT LENSES?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. ARE YOU TAKING ANY MEDICINE (S)? INCLUDING NON-PRESCRIPTION MEDICINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IF YES, WHAT MEDICINE (S) ARE YOU TAKING _____							
7. DO YOU HAVE PROLONGED BLEEDING?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	WOMEN ONLY:			
				ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?			
				ARE YOU NURSING?			
				ARE YOU TAKING BIRTH CONTROL PILLS?			

PLEASE CHECK ONE BOX

		YES	NO			YES	NO
ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:				HIVES OR SKIN RASH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LOCAL ANESTHETICS LIKE NOVOCAINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FAINING OR DIZZY SPELLS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PENICILLIN OR OTHER ANTIBIOTICS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SULFA DRUGS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS OR HIV INFECTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BARBITURATES, SEDATIVES OR SLEEPING PILLS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CODEINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ASPIRIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS OR RHEUMATISM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IODINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	JOINT REPLACEMENT OR IMPLANT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ANY METALS (E.G., NICKEL, MERCURY, ETC.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH ULCER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LATEX / RUBBER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OTHER (PLEASE LIST) _____				TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:				PERSISTENT COUGH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	COUGH THAT PRODUCES BLOOD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SCARLET FEVER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CHEMOTHERAPY (CANCER, LEUKEMIA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART DEFECT OR HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SEXUALLY TRANSMITTED DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART TROUBLE, HEART ATTACK, OR ANGINA ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY OR SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CHEST PAIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SHORTNESS OF BREATH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PACEMAKER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUSNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART SURGERY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TONSILLITIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIGH/LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TUMORS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CONGENITAL HEART PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MENTAL HEALTH CARE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SWELLING OF FEET, ANKLES, HANDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BACK PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS, JAUNDICE OR LIVER DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CHEMICAL DEPENDENCY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MITRAL VALVE PROLAPSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SINUS TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CORTISONE TREATMENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LUNG OR BREATHING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	COLD SORES/FEVER BLISTERS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA OR HAY FEVER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HYPOGLYCEMIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				EATING DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NOTES: _____