FULMER DENTISTRY

Patient Information Form

Please fill out the below form before your visit. All information complies with HIPPA standards. You are not required to give your social security number. If you have any questions, please call us 262.657.5408.

Patient Information

Date:_____ Phone Number:_____ Alternate Phone Number:_____

Last Name:_____ First Name:_____ MI:____ SS/HIC/Patient ID #:_____

Mailing Address:_____ Email Address:_____

City:_____ State:_____ Zip Code:_____ Age: _____ Birthdate: _____

Sex: ☐ M ☐ F ☐ Married ☐ Separated ☐ Widowed ☐ Single ☐ Minor ☐ Divorced ☐ Partnered

Patient Employer/School:_____ Occupation:_____

Employer/School Address:_____ Employer/School Phone:_____

Whom may we thank for referring you?:_____

In case of emergency who should be notified?:_____ Phone:_____

Primary Insurance

Person Responsible for Account:

Last Name:_____ First Name:_____ MI:____

Relation to Patient:_____ Birthdate:_____ SS/HIC/Patient ID #:_____

Mailing Address (if different from patient):_____ Phone Number:_____

City:_____ State:_____ Zip Code:_____

Person Responsible Employed By:_____ Occupation:_____

Business Address:_____ Business Phone:_____

Insurance Company:_____

Contract #:_____ Group #:_____ Subscriber #:_____

Names of other dependents covered under this plan:_____

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FULMER DENTISTRY

Dental History

Reason for Today's Visit:_____ Date of Last Dental Care:_____

Former Dentist:_____ Date of Last Dental X-Rays:_____

Mailing Address:_____

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

☐ Bad breath	☐ Bleeding gums	☐ Clicking or popping jaw	☐ Grinding teeth
☐ Sensitivity to hot	☐ Loose teeth or broken fillings	☐ Periodontal treatment	☐ Sensitivity to sweets
☐ 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?:_____

Medical History

Physician's Name:_____ Date of Last Visit:_____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva?: ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine)?: ☐ Yes ☐ No

Have you had any serious illnesses or operations?: ☐ Yes ☐ No If yes, describe:_____

Have you ever had a blood transfusion?: ☐ Yes ☐ No If yes, give approximate dates:_____

(Women) Are you pregnant?: ☐ Yes ☐ No Nursing?: ☐ Yes ☐ No Taking birth control pills?: ☐ Yes ☐ No

Check if you have or have had any of the following:

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

MEDICATIONS: List medications you are currently taking:_____

Allergies:_____

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FULMER DENTISTRY

Patient Financial Responsibility Form

Thank you for choosing Fulmer Dentistry as your dental healthcare provider. We are honored by your choice and are committed to providing you with the highest quality dental care in the most gentle and efficient manner. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Agreement

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment of their treatment and care.
- Patients who have dental insurance are responsible for the payment of co-pays, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan, at time of service.
- Payment is due in full at the on the day the treatment is rendered unless prior arrangements have been made.
- Payments may be made using cash, check, Visa, MasterCard and/or Discover. For your convenience, we also accept CARECREDIT as a financing option available only for healthcare expenses.
- Outstanding balances on your account are discouraged, and must be cleared before the next appointment or within 60 days of treatment, whichever comes first. Appointments for non-emergency treatment may need to be postponed pending payment of outstanding balances. Amount due and not paid in full within 60 days will be charged interest at a rate of 1% per month in addition to a $5.00 monthly billing fee per statement.
- A returned check fee of $30.00 (subject to change as bank fees increase) will be added to your account for any returned check. Before we accept another payment by check, the $30.00 fee plus full payment for the check that did not clear must be paid.

Insurance Information

We are pleased to assist you by submitting claims to your insurance company to help you receive your maximum allowable benefits. In order to do this we need your insurance card and/or insurance policy with you on your first visit of every calendar year. The patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct and updated.

Appointments

Your dental appointments are scheduled carefully. Time, trained personnel and dental equipment are reserved for each procedure. Missed appointments add to the cost of dental care when reserved facilities are left waiting empty. We request 24 hours advanced notice for rescheduling your appointment. Your account will be charged a broken appointment fee of $50.00 for missed appointments without proper notification.

Patient Authorizations

- By my signature below, I hereby authorize Fulmer Dentistry to release dental and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payers, and other dental specialists or healthcare entities required to participate in my care.
- By my signature below, I authorize Fulmer Dentistry personnel to communicate by mail, text messaging, answering machine message, and/or email according to the information I have provided in my patient registration information.

☐ **I have read, understand, and agree to the provisions of this patient financial responsibility form:**

I understand and accept the financial and the dental insurance policies listed above and have had any and all questions answered to my satisfaction. I agree to pay for all treatment in a timely fashion as described so as to avoid any additional fees.

Signature of Patient or Guardian Date

☐ **Waiver of Patient authorizations:**

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

Signature of Patient or Guardian Date