ALAN WOOD DMD
GENERAL DENTISTRY

HEALTH INFORMATION

Date of Last Dental Visit: Reason for this visit:

Have you ever had any of the following? Please check those that apply:

□ HIV	□ Heart Murmur	□ Tuberculosis
□ Arthritis	□ Jaundice	□ Venereal Disease
□ Blood Disease	□ Mental Disorder	□ Allergies
□ Dizziness	□ Substance Abuse	□ Artificial Joints
□ Fainting	□ Radiation Treatment	□ Cancer
□ Hay Fever	□ Sinus Problems	□ Stroke
□ Epilepsy	□ Anemia	□ Ulcers
□ Glaucoma	□ Asthma	□ Penicillin Allergy
□ Head Injuries	□ Diabetes	□ Other
□ Hepatitis	□ Excessive Bleeding	□ Codeine Allergy
□ Kidney Disease	□ Growths	□ Rheumatic Fever
□ Pacemaker	□ Heart Disease	
□ Respiratory Problems	□ High Blood Pressure	
□ Stomach Problems	□ Liver Disease	
□ Tumors	□ Pregnancy Due Date:______	

Please list ALL medications you are now taking:

Have you ever had any complications following dental treatment? □ Yes □ No
If yes, please explain: ______________________________

Have you been admitted to a hospital or needed emergency care during the past 5 years? □ Yes □ No
If yes, please explain: ______________________________

Within the past year, have there been any changes in your general health? □ Yes □ No

Are you now under the care of a physician? □ Yes □ No
If yes, please explain: ______________________________

Do you have any health problems that need further clarification? □ Yes □ No
If yes, please explain: ______________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctors at the next appointment without fail.

Signature: ______________________________ **Date:** ____________________

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AUTHORIZATION

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate. I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf and on behalf of my dependents (if any).

_______________________________________ _____________________

Signature of Patient/Representative **Date**

CONSENT FOR SERVICES

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. All emergency dental services or any dental services performed without previous financial arrangements must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand and agree that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

AGREEMENT TO PAY: The undersigned accepts the fee charged as a lawful debt and promises to pay said fee including the cost of collection (33.33%), attorney fees, and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama, or any other state. I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination. In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.
I GRANT MY PERMISSION TO YOU OR YOUR ASSIGNEE TO TELEPHONE ME TO DISCUSS THIS STATEMENT OR MY TREATMENT.
□ I HAVE READ THE ABOVE CONDITIONS OF TREATMENT AND PAYMENT AND AGREE TO THEIR CONTENT.

____ _____________________

Signature of patient, parent, or guardian (responsible party) Date

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WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE?

□ Patient □ Doctor's Office □ Internet □ Yellow Pages □ Insurance Co.

____
Name

PATIENT INFORMATION

Patient Name: ______________________ Date of Birth: __________ Age: ________
Last First MI

Gender: □ Male □ Female Family Status: □ Single □ Married □ Child □ Other

Social Security #: ______________ Telephone # __________ __________ ___ ________
Home Work Cell

Address: ____
Street Apt.# City State zip

Employer: ____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

The following is for: □ Patient's Spouse □ Patient's Parent □ Person Responsible for Payment

Name: ______________________ Date of Birth: ____________ □ Male □ Female

Social Security #: ______________ Telephone #: __________ __________ __________
Home Work Cell

Address: ____
Street Apt.# City State Zip

Employer: ________________ Employer's Address: ________________

Employer Telephone #: ____

INSURANCE INFORMATION

Primary:

Name of Insured: ______________________ Date of Birth: ______________________

Address: ____

Telephone #: __________ __________ __________
Home Work Cell

Social Security #: ______________ □ Male □ Female Employer: ______________

Insurance Plan Name: ______________ Contract/ID #: ______________ Group #: ________

Relationship to Patient: □ Spouse □ Parent □ Self □ Step-Parent □ Other

Secondary:

Name of Insured: ______________________ Date of Birth: ______________________

Address: ______________________ Telephone #: ______________________

Social Security #: ______________ □ Male □ Female Employer: ______________

Insurance Plan Name: ______________ Contract/ID #: ______________Group #: ________

Relationship to Patient: □ Spouse □ Parent □ Self □ Step-Parent □ Other

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PURPOSE OF CONSENT : By signing this form you are consenting to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:

CONTACT NAME: KRISTI O'NEAL
TELEPHONE NUMBER : (334) 361-0244
ADDRESS: 474 MCQUEEN SMITH ROAD PRATTVILLE, AL 36066

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

- You may refuse to sign this acknowledgement

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

____

Name Date Signature

FOR OFFICE USE ONLY

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

□ Individual Refused to Sign □ Communications barriers prohibited obtaining the acknowledgement
□ An emergency situation prevented us from obtaining acknowledgement □ Other (Please Specify)