

## MAURO FAMILY DENTISTRY FINANCIAL POLICY

For the convenience of our patients, we offer several alternatives to pay for your dental services. Please read through the following choices.

For patients with an insurance company in which we are participating, preventive and basic services will be sent to your insurance company for payment to this office with co-pay due after insurance payments. For major work, estimates of insurance co-payments will be given and are due by the completion of those services.

For patients who do not have dental insurance payment plans are available for major work and these arrangements must be made in advance. We also offer interest free financing through Chase Bank.

For your convenience we do accept cash, checks, Master Card and Visa. (there will be a \$30.00 charge on all returned checks)

Past due accounts will be turned over to a collection agency and all fees associated with this process will be billed to the patient. If financial arrangements have been made and payments are delinquent, this office reserves the right to reschedule any non-emergency appointments until the account is brought to a current status.

We believe that your time is valuable. As a consequence, we maintain a daily schedule and strive to adhere to it. We truly appreciate your patience at these times. We urge that you be on time for your appointments so that patients that follow you on the schedule will not be delayed. Please understand, however that emergencies do occasionally occur and may cause delays. Once an appointment has been reserved for you, we require that a minimum notice of **24 hours** be given if you will be unable to keep the appointment. This courtesy on your part will make it possible to schedule another patient waiting for treatment. **Please note that there will be a fee of \$39.00 per hour for a broken or missed appointment without the minimum required notice. We also reserve the right to dismiss a patient from the practice who has missed 3 appointment times or who habitually cancels appointments.**

In an effort to make your dental care more affordable we are preferred providers of most Insurance Companies. We are **NOT** providers in any **DMO** or **HMO** plans. It is important that you understand that as your dental care provider, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility if there is a problem with the insurance payment.

We will gladly answer any questions you may have relating to your insurance. You must realize however that: 1. Not all services are a covered benefit in all contracts. 2. It is your obligation to know your contract limitations regarding specific procedures. 3. Any information our office gives regarding your insurance coverage is an estimate.

**I have read, understand and agree to the above office policy. I understand that I am fully responsible for the fees of services rendered, regardless of any insurance that I may have.**

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

### Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last, First MI (Preferred Name)  
 Gender: \_\_\_\_\_ Family Status: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Cell: \_\_\_\_\_  
 Address: \_\_\_\_\_  
Street Apartment #  
 \_\_\_\_\_  
City State Zip Code

### Health Information

#### Do You Have or Have you ever had any of the following?

Yes		No		Yes		No		Yes		No	
AIDS/ HIV	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding..	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
Allergies/ List	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/ Seizures....	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis....	<input type="checkbox"/>	<input type="checkbox"/>
Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorders...	<input type="checkbox"/>	<input type="checkbox"/>	Tumors.....	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints....	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness.....	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant.....	<input type="checkbox"/>	<input type="checkbox"/>	S T D s.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>	Due date:	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problem	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment...	<input type="checkbox"/>	<input type="checkbox"/>	M V P.....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems..	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease...	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis /Jaundice...	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>
			High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism.....	<input type="checkbox"/>	<input type="checkbox"/>	Angina.....	<input type="checkbox"/>	<input type="checkbox"/>

- Have you ever had any complications following dental treatment?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Are you allergic to or have had a reaction to any of the following? Local Anesthetic, Sulfa, Penicillin, Iodine, Aspirin, Latex Rubber, any Metals, Other \_\_\_\_\_
- Are you now under the care of a physician?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_
- Are you taking any medications prescription or non-prescription?  Yes  No  
If yes, please list: \_\_\_\_\_

### Dental History

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

#### Check (✓) if you have had problems with any of the following:

Bad breath.... <input type="checkbox"/>	Grinding teeth..... <input type="checkbox"/>	Sensitivity to hot, cold, sweets... <input type="checkbox"/>
Bleeding gums..... <input type="checkbox"/>	Periodontal treatment.... <input type="checkbox"/>	Sensitivity when biting..... <input type="checkbox"/>
Loose teeth or broken fillings.... <input type="checkbox"/>	Sores or growths in your mouth... <input type="checkbox"/>	Food collection between teeth..... <input type="checkbox"/>
Prolonged bleeding after extraction.... <input type="checkbox"/>	Orthodontic treatment.... <input type="checkbox"/>	
How often do you brush? _____	How often do you floss? _____	