Adult Patient Information Patient's name Residence/Mailing address____ How long at this address _____ Home phone _____ Work phone ____ Cell phone _____ Previous Address (if less than 3 years)_____ Birthdate Social Security #_____Email Address_____ Marital Status: Single Married Widowed Separated Divorced Employer ______ Occupation _____ No. yrs employed _____ Spouse's Name______ Relationship to patient_____ Occupation_____ No. yrs employed____ Employer Social Security#_____ Birthdate_____ Work Phone_____ Whom may we thank for referring you to our office?_____ **Dental Information** Insured's Social Security #_____ Insured's Name Insurance Company Group No. Member id No. Insurance Co. Address Phone No. Do you have dual coverage?______ Yes__ No__ If Yes:_____ Insured's Name Insured's Social Security # Insurance Company_____ Group No ._____Member id No.____ Insurance Co. Address______ Phone No._____ **Emergency Information** Name of nearest relative not living with you_____ Complete address______ Phone Number_____ I understand that If I choose to apply for Financing with CareCredit, credit bureau reports may be obtained.

Updates (Date & Initial)____

PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Patient's name		First		Middle
AddressStreet		City		Zip
Nickname	Birthdate	Social Security	/#	
School	Sports/Hobbies_			
Parent or guardian name	DOTE A 10 STERRED 1.3	entre de	STATE OF THE STATE	to parform a complete con-
Whom may we thank for referring	you to our office?	enters all the eleven	notify theorems and	n mil sense near at an and at
	RESPONSIBL	E PARTY INFORMATI	ON	
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Residence		First		Middle
Street	THE REPORT OF THE PARTY OF THE	City		Zip
Mailing AddressStreet	and the same and t	City		Zip
		est pe ants		
How long at this address?				
Cell/other phone				
Previous Address (If less than 3				t- Dations
			Relationship to PatientNo. years employed	
Employer Spouse's Name				
		OccupationBirthdate		
Social Security #				
	DENTAL INC	URANCE INFORMATI	ON	
Insured's Name				
Insurance Company			Local No	
Insurance Co. Address	A PERSON OF CREATE SEC.	hat you feel we should	Phone No	ALCOHOL DE CONTROL DE
Do you have dual coverage? Y		If yes:		
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Insured's Name				
Insurance Company	Group	No	Local No	
Insurance Co. Address			Phone No	
	EMERGE	NCY INFORMATION		
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Complete addressStreet		City		Zip
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I understand that, where approp	riate credit hureau report	s may be obtained		
LIMINES CHOIC ASS OF NO. (II Y 63				
Parant Signatura				

MEDICAL HISTORY

	Physician			Date of Last Visit			
Address			Phone				
Please	circle Ye	es or No (If Yes, ple	ase fill in details)				
Voc	No	le the nationt taki					
Yes		Is the patient allo	ng any medication? rgic to any medication?				
Yes Yes	No No	History of a main	rillness?				
Yes	No	Has the nations h	ad any operations?	con/h			
Yes	No	Ever been involve	ad any operations:	1.46			
	No	History of a major illness? Has the patient had any operations? Ever been involved in a serious accident? Have seen a physician in the last 12 months? Why?					
Yes	INO	Female Patients	only.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
Yes	No	Has menstruation	n started?				
Yes	No	Is the patient pre	n started?gnant?	AF DRINK TION			
				Lies is the			
Circle	any of the	medical conditions	s below that the patient has had	or currently has			
		ling/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia		
Anemi		g/i ioiniopinna	Dizziness	Herpes	Prolonged Bleeding		
Arthriti			Epilepsy	High Blood Pressure	Radiation/Chemotherapy		
Asthm	a or Havi	ever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever		
Bone I	Disorders	Tiporeleday Je	Heart Problems	Kidney problems	Tuberculosis		
Conge	nital Hea	rt Defect	Heart Murmur	Nervous Disorders			
Are the	ere any n	nedical conditions w	e have not discussed that you	feel we should be aware of?	Tumor or Cancer		
 		the American	- Contract	THE PARTY OF THE P			
			DENTAL H	ISTORY			
				D 1 (1 1 1 1 1			
Gener	al Dentis	1	DENTAL MAURICIA	Date of last visit			
Gener What	al Dentis		ur teeth?				
Yes	No						
Yes Yes	No No	Is the patient pre	sently in any dental pain?d any unfavorable reaction to de	entistry?	VV TK Prione		
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ARENA DENTAL GROUP

WE APPRECIATE THE TRUST YOU HAVE PLACED IN US!

Policy & Financial Agreement

Dr. Candace Thomas and staff are pleased to welcome you to our practice. We look forward to providing you and your family with quality care rendered with the "latest and greatest" dentistry has to offer.

Payment is expected upon rendering services. All co-pays, deductibles, etc. must be made on the date of service.

We offer Care Credit, a "Dental Charge Card" that allows small monthly payments with extended plans for up to 18 months, no interest, based on your credit.

We gladly accept Cash, All Major Credit Cards-American Express, Discover, MasterCard, Visa and Care Credit.

BROKEN APPOINTMENTS

We require a 24 hour notice for all broken appointments otherwise there is a \$25.00 broken appointment fee per 30 minutes due at the time of your next appointment.

IMPORTANT INSURANCE INSTRUCTIONS

We will file your insurance claim(s) as a courtesy to you and your family. Professional services are rendered and charged to you, not the insurance company. After 60-days, the account balance is your responsibility.

We do not determine the amount of coverage you will receive; your insurance carrier determines this. Any questions regarding coverage, deductibles, and limitations should be directed to your current carrier.

At time of service, we will contact your insurance carrier and get an "estimate of payment" for services rendered based on your coverage percentage rate for various dental procedures. The "estimated" portion your insurance does not cover is requested in full at time of service. After your insurance carrier makes payment, you will receive a statement of your account and bill, if there is a difference in the procedure charge and allowed amount by carrier.

All account balances must be paid within 10 days, after receipt of statement. Please be advised that if payment is not made on time, all outstanding amounts shall be deemed to be due immediately and payable without further notice. Failure to pay account may result in INTEREST, COLLECTIONS, AND/OR ATTORNEY FEES being added to the outstanding balance. These charges will be the patient or parent/guardian's responsibility.

I have read and reviewed the outl	ined statements above:	
Signature	Date	
Patient Name		

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy	Practices and	I have	been	provided
an opportunity to review it.				

Name	Birth Date	
Signature	Date	