Oswego Dental Specialists Welcomes You

Patient Information

Date___________________ Social Security Number________________________________
Name____
(Last, First, M.I.)
Address____
City, State, Zip____
Sex: ___M ___ F Birthdate______________ Marital Status____________________
Employer/School:____
Occupation:____
Whom may we thank for referring you?____

Contact Information

Home:________________________________ Work:________________________________
Cell:__________________________________Email:______________________________
Emergency Contact:____
Relationship:____

Primary Insurance

Subscriber Name:___________________________ SS#_____________________________
Relation to Patient:_________________________Birthdate:_______________________
Address (if different from patient)____
City_________________________________State________________Zip________________
Responsible Person Employer____
Business Address____________________________________Phone___________________
Insurance Company____
Group/Plan#________________________ Member ID_______________________________
Other dependents covered under this plan:_______________________________________

Additional Insurance

Is patient covered by additional insurance? ___Y ___N
Subscriber Name:___________________________ SS#_____________________________
Relation to Patient:_________________________Birthdate:_______________________
Address (if different from patient)____
City_________________________________State________________Zip________________
Responsible Person Employer____
Business Address____________________________________Phone___________________
Insurance Company____
Group/Plan#________________________ Member ID_______________________________
Other dependents covered under this plan:_______________________________________

Financial Agreement

Insurance

Our office will gladly work with you to get maximum benefit available to you. Most dental insurance companies do not cover 100% of your cost of treatment. Because of this you will be asked to pay half of all non-preventative procedures at the time treatment is rendered. Any resulting balances after insurance payment has cleared will be charged on your provided credit card on consent to pay form. Any resulting credit balances that exist after insurance payment has cleared will be promptly refunded to you.

Because the insurance policy is an agreement between you, your employer and the insurance company, the responsibility for all charges lies with you. If after 60 days, the insurance company has not paid on the claims, you will be responsible for the balance.

Payment Options

1. Cash or Check – We are happy to offer a 10% pre-payment courtesy discount for all treatment paid in full by cash or check on the day treatment is rendered.
2. Credit Card – We accept Visa and Mastercard

Consent to Pay

I authorize Oswego Dental Specialists to keep my signature on file and to charge my Visa or Mastercard account for balance of charges not paid by insurance company within 60 days.

Patient Cardholder Name____

Billing Address____

Account Number____

Exp. Date_______________________________________ Sec Code____________________________

Signature____Date_________________________

Oswego Dental Specialists

Cancellation Policy
Restorative and Hygiene Appointments

We ask for 48 hours advance notice for canceling or rescheduling an appointment, or a $50 fee may be assessed to your account.

NOTE: All cancellation fees must be paid prior to scheduling another appointment.
The treatment that is planned is specific to YOU. It is important for you to keep your scheduled dates and times to properly complete your treatment.
A broken appointment is a loss to three people:

- The patient who missed the valuable time
- The patient that could have taken that valuable time
- The doctor who was fully staffed and prepared for the appointment

ACKNOWLEDGEMENT AND RELEASE

Insurance

We provide services for our patients with the understanding that they are responsible for payment in accordance with our financial policy. We will prepare and submit forms are reports to assist you in obtaining maximum benefits available, however, the dentists treatment recommendations and fees are not affected by the presence or absence of insurance benefits. Treatment recommendations are based on your dental needs and desires and are not a reflection of your dental benefits. Your dental benefits are a contract between you, your employer, and the insurance company. Therefore we do not confirm insurance eligibility or predetermine recommended treatment.

Collection

In the event the balance becomes more than 60 days overdue, billing may be turned over to an outside collection agency. The responsible party listed agrees to pay interest, collection and other legal expenses related to collection of fees owed, including reasonable attorney fees and court costs. Waiver of any breach of any time or condition shall not constitute a waiver of any further term or condition.

____

Signature

Credit Card #___________________________Exp_______________ Sec Code_______________

Patient Name____ **Birth date** ____________________

DENTAL HISTORY

What is the reason for today's visit? ____

When was your last visit to a dentist? ____

Have past dental experiences been satisfactory? ____

How do you feel about the appearance of your teeth? ____

Do you have or have you had any of the following? (Please check all that apply to you)

- o Bleeding gums
- o Broken fillings
- o Chronic bad breath
- o Decayed teeth
- o Food catches between teeth
- o Grinding or clenching of teeth
- o Injury to teeth or jaw
- o Loose teeth
- o Orthodontic treatment
- o Periodontal treatment
- o Painful or locking jaw
- o Sensitivity to sweet, hot, cold, biting
- o Sores, growths or swelling in mouth

MEDICAL HISTORY

Do you have or have you had any of the following? (Please check all that apply to you)

- o Anemia
- o Arthritis, rheumatism
- o Artificial heart valves
- o Artificial joints
- o Asthma, sinus problems
- o Autoimmune disease
- o Back problems
- o Blood disease
- o Abnormal bleeding, prolonged healing, bruising easily
- o Cancer
- o Chemical dependency
- o Chemotherapy
- o Circulatory problems
- o Cortisone treatments/steroids
- o Cough, persistent/chronic
- o Cough up blood
- o Diabetes
- o Epilepsy/seizures
- o Fainting
- o Glaucoma/eye disorders
- o Headaches, migraine headaches
- o Heart murmur
- o Heart disease (describe)
- o Hemophilia
- o Hepatitis/liver diseases/jaundice
- o High blood pressure
- o Low blood pressure
- o HIV positive
- o AIDS
- o Kidney disease
- o Mitral value prolapse
- o Malignancy or tumor/cyst
- o Nervous disorders
- o Pacemaker
- o Psychiatric care
- o Radiation treatment
- o Respiratory disease
- o Rheumatic fever/rheumatic heart disease
- o Shortness of breath
- o Skin rash
- o Stroke
- o Congestive heart failure
- o Thyroid disease
- o Tobacco habit
- o Tuberculosis
- o Ulcer/digestive disorders
- o Venereal disease

Physician____Tel #_________________________

Date of last physical exam:____________________

Please list all medications you are currently taking as well as over-the-counter medications, herbal remedies, vitamins, homeopathic remedies: ____
____

Allergies/reactions to medications, or other allergies? ____

(Women) Are you pregnant? _________ Nursing?_________ Taking birth control pills?_________

Are you presently under a physician's care? _________Explain____________________________________

Do you consider yourself to be in good health?____

Please describe any impending operations, recent injuries or other information the dentist should be aware of:
____

Patient signature_________________________________Date___________ Dentist's initials___________