Patient Information Form

PATIENT *(please print)*

Name_____ Preferred Name_____

Male / Female Single / Married / Child / Dependant

Phone: Home _____ Cell _____ Work _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security # _____

Email _____

Emergency Contact: _____ Relationship _____

Phone: Home _____ Cell _____ Work _____

RESPONSIBLE PARTY *(if other than the patient)*

Person Responsible for this Account _____ Relationship to patient _____

Phone Number: Home_____Work _____

Social Security #_____

Address _____ City _____ State _____ Zip _____

Occupation _____ Employer _____

Business Address _____ City _____ State _____ Zip _____

DENTAL INSURANCE INFORMATION

Policy Holder/ Subscriber Name _____ Relationship to Patient _____

Phone: Home _____ Cell _____ Work _____

Social Security #_____ Date of Birth _____

Employer _____ Group # _____ Policy/ ID # _____

Primary Insurance Company Name & Phone # _____

Do you have any additional dental coverage? YES / NO If circled yes, complete the following.

Policy Holder/ Subscriber Name _____ Relationship to Patient _____

Phone: Home _____ Cell _____ Work _____

Social Security #_____ Date of Birth _____

Employer _____ Group # _____ Policy/ ID # _____

Secondary Insurance Company Name & Phone # _____

Health History Form

MEDICAL INFORMATION

Are you now under the care of a physician? YES ☐ NO ☐
Physicians Name: _____ Phone Number: _____
Had orthopedic total (hip, knee, elbow, finger) joint replacement within the last 3 years? YES ☐ NO ☐
Have you had a serious illness, operation, or been hospitalized in the past 5 years? YES ☐ NO ☐
If yes, what was the illness or problem? _____
Are you taking or have you recently taken any prescription or over the counter medicine(s)? YES ☐ NO ☐
If yes, please list all, including vitamins, natural or herbal preparations and/or diet supplements:
_____

ALLERGIES

Are you allergic to or have had a reaction to:

☐ Local Anesthetics ☐ Aspirin ☐ Penicillin or other antibiotics ☐ Sulfa Drugs
☐ Codeine or other narcotics ☐ Metals ☐ Latex (rubber) ☐ Hay Fever (seasonal)
☐ Other If yes, please explain _____

Medical History

Check Each Item	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/ HIV Positive			Congenital Heart Prob.			Hypoglycemia			Respiratory Disease		
Alzheimer's Disease			Diabetes-Type___			TMJ/ Jaw Pain			Rheumatic Fever		
Alcoholism			Drug Addiction			Joint Replacement			Scarlet Fever		
Anemia			Eating Disorder			Kidney Problems			Seizures		
Angina			Emphysema			Leukemia			Shortness of Breath		
Arthritis			Epilepsy			Liver Disease			Shingles		
Artificial Heart Valves			Faint/Dizziness			Low Blood Pressure			Sickle Cell Disease		
Asthma			Fear of Dentistry			Lung Disease			Steroid Medications		
Back/ Neck Problems			Hay Fever			Migraines			Stomach Disease		
Bleed Easily			Heart Attack			Mitral Valve Prolapse			Stroke		
Blood Disease			Heart Murmur/ Disease			Nervousness			Swollen Ankle		
Blood Transfusion			Heart Pacemaker			Osteoperosis			Thyroid Problem		
Cancer			Hemophilia			Persistant Cough			Tonsillitis		
Cold Sores/ Blisters			Hepatitis- Type___			Prolonged Bleeding			Tuberculosis		
Chemical Dependency			Herpes			Prosthetic Joints			Ulcers		
Chemo/ Radiation Tx			High Blood Pressure			Psychiatric Care			Venereal Disease		
Circulatory Problem			Hives/ Rash			Recent Weight Loss			Yellow Jaundice		

Other: _____

Women – Please circle one: Are you Pregnant? **YES / NO** Are you nursing? **YES / NO**

Do you:
Use tobacco? **YES / NO**
Have to or ever had to Pre-medicate prior to dental treatment? If yes, why? _____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my or other patient's health. It is my responsibly to inform the dental office of any changes in my medical status. **PATIENT NAME:** _____

Patients Signature	Date	Doctor's Signature	Date
Patients Signature	Date	Doctor's Signature	Date
Patients Signature	Date	Doctor's Signature	Date
Patients Signature	Date	Doctor's Signature	Date
Patients Signature	Date	Doctor's Signature	Date

Cosmetic & Implant Dentistry

Dr. Michael D. Turck, D.D.S.
931 Providence Road
Chesapeake, VA 23325

Acknowledgement For Services

OFFICE CONSENT

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics and other medications as necessary. I understand that I can ask for a complete recital on any possible complication.

Checks returned by your bank for insufficient funds will be charged a $50.00 processing fee.

Providence Dental Care is committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

ADULT PATIENTS
Adult patients are responsible for full payment at time of service.

MINORS ACCOMPANIED BY AN ADULT
The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

UNACCOMPANIED MINORS
The parents or guardians are responsible for full payment at time of service. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, or to Visa, Master Card or Discover. We do not accept American Express payments.

DELINQUENT PAYMENTS
It is our policy to charge finance fees at 1.5% for outstanding patient balances after the balance has been outstanding 30 days. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of $25.00.

MISSED APPOINTMENTS
Unless cancelled at least 48 hours in advance, our policy is to charge for missed appointments at the rate of $37.50 per each 30 minutes of missed appointment time. Please help us service you better by keeping scheduled appointments.

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

Patient's signature _____ Date _____

Dr Michael D. Turck, DDS, PC
931 Providence Road
Chesapeake, VA 23325

Acknowledgement of Receipt of Notice of Privacy Practices.

* You May Refuse to Sign This Acknowledgment*

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

Print Name:_____

Signature:_____

Date:_____

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)

PROVIDENCE DENTAL CARE
DR. MICHAEL D. TURCK DDS, PC
931 Providence Road
Chesapeake VA 23325
757-366-0330

FINANCIAL RESPONSIBILITY AGREEMENT

I hereby accept total responsibility for any and all charges connected with the planned treatment for _____ at Providence Dental Care.

I understand that Dr. Michael Turck DDS, PC will file my insurance for me only as a courtesy to me and I am solely responsible for payment of my account. **I understand that payment is due at time of service.** I understand it is my responsibility to disclose information at this time on each insurance company that might help me pay my account in full. **Failure to provide correct insurance information at the time of my appointment will consider me to be self-paying**. I understand it is solely my responsibility to file any further claims to secondary and tertiary insurance companies not disclosed at this time to Michael D. Turck DDS, PC. My signature below indicates I can speak and read English and that I fully understand and agree to the forgoing and have no further questions.

I, _____ (patient/guarantor) accept responsibility for all services rendered on my behalf including 1.5 % interest per month (18% A.P.R) on unpaid balances after thirty (30) days. In the event of default on any payment due to Michael D. Turck DDS, PC, I agree that should this account be referred to any attorney for collection, to pay all collection costs including attorney fees of 33 ⅓% of the amount due and owing when turned over for collection.

CANCELLATION POLICY/EMERGENCY VISITS

I understand broken or cancelled appointments increases costs and fees for other patients. I will notify the office with at least a 48 notice if I must cancel or reschedule an appointment. If not, I will be charged the cancellation fee of $50.00 for the first appointment and $75.00 thereafter. Emergency visits not scheduled during regular scheduled hours will have a $100.00 emergency charge added to the regular co-payment.

Signed _____ Date _____

Litigation cases: payment of fees are the patient's responsibility. We do not bill attorneys nor are they responsible for paying our fees. We only file for insurance when applicable. Litigation cases are not taken on credit.

INSURANCE ASSIGNMENT

The undersigned hereby authorizes the filing of any insurance in force and the direct payment to Michael D. Turck DDS, PC of ay amounts due on my claim under the attached stated policy. Michael D. Turck DDS, PC will abide by policies of insurance companies in which they participate by contract.

I understand that my insurance policy is a contract between my insurance and me and does not in any way obligate Dr. Turck. I am financially responsible to Michael D. Turck DDS, PC for all fees due and not covered by my insurance company, and agree to make payment in full when Michael D. Turck DDS, PC requests me to and/or at time service is rendered. **It is my responsibility to go to my insurance provider and know what is covered by my insurance. Michael D. Turck DDS, PC makes no guarantees about any insurance coverage.**

I understand that if there is a medical claim needed for dental that Michael D. Turck DDS, PC does not submit medical claims.

I do not have insurance (initial)_____

Signed_____ Date _____