Dr. Marilia Tate

Preventive • Cosmetic • Restorative
DENTISTRY

PATIENT INFORMATION

TODAY'S DATE: _____ HOME PHONE: _____ CELL PHONE: _____

E-MAIL: _____ SOCIAL SECURITY NUMBER _____

NAME: _____ PREFERRED NAME: _____
LAST NAME FIRST NAME INITIAL

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

Who referred you to this office: _____

SEX: ❑ M ❑ F AGE: _____ BIRTH DATE: _____ ❑ SINGLE ❑ MARRIED ❑ WIDOWED ❑ SEPARATED ❑ DIVORCED

IF PATIENT IS A MINOR, RESPONSIBLE PARTY: _____ WILL YOU RECEIVE CALLS AT WORK? Y N

PATIENT EMPLOYED BY: _____ OCCUPATION: _____

BUSINESS ADDRESS: _____ BUSINESS PHONE: _____

IN CASE OF EMERGENCY, WHOM SHOULD WE NOTIFY? _____ PHONE: _____

SPOUSE NAME: _____ SPOUSE CELL #: _____ WORK #: _____

PRIMARY INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT: _____ PHONE #: _____
LAST NAME FIRST NAME INITIAL

RELATION TO PATIENT: _____ BIRTH DATE: _____ SOCIAL SECURITY #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PERSON RESPONSIBLE EMPLOYED BY: _____ OCCUPATION: _____

BUSINESS ADDRESS: _____ BUSINESS PHONE: _____

INSURANCE COMPANY: _____

CONTRACT OR I.D. NUMBER: _____ GROUP NUMBER: _____

NAME OF OTHER DEPENDENTS COVERED UNDER THIS PLAN: _____

ADDITIONAL INSURANCE

IS PATIENT COVERED BY ADDITIONAL INSURANCE YES ❑ NO ❑

SUBSCRIBER NAME: _____ RELATIONSHIP TO PATIENT: _____ BIRTH DATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SUBSCRIBER EMPLOYED BY: _____ BUSINESS PHONE: _____

INSURANCE COMPANY: _____ SOCIAL SECURITY NUMBER: _____

CONTRACT NUMBER: _____ GROUP NUMBER: _____ SUBSCRIBER NUMBER: _____

NAME OF OTHER DEPENDENTS COVERED UNDER THIS PLAN: _____

ASSIGNMENT AND RELEASE

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL NECESSARY INFORMATION TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

I, THE UNDERSIGNED, HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ATTENDING DENTIST.

DATE: _____ **SIGNATURE** X _____
Signature of Patient, Parent or Guardian

SIGNATURE _____
(State relationship if other than patient)

Reorder: Kwik Kopy 979-5541

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Consent For Services

ALL PATIENTS ARE RESPONSIBLE FOR FULL PAYMENT OF THEIR ACCOUNT(S) AT THE TIME SERVICES ARE RENDERED UNLESS PRIOR ARRANGEMENTS ARE APPROVED.

Our office accepts insurance payments on behalf of the patients receiving treatment; however, the payment for services rendered to an insured patient is the responsibility of the patient, not the insurance company. As a courtesy to our patients, we will be happy to assist in completing insurance forms relative to treatment, however, since our professional services are rendered to you, not the insurance provider, you are directly responsible to us for your financial obligations. We do not accept responsibility for collection of patient insurance claims. In addition, there may be certain services I feel are appropriate for your treatment that are not typically covered by your dental insurance company. For certain services, you will be expected to pay the fee schedule difference for that service or pay for the service in full. For example, your dental insurance contract may reduce their payment to an amalgam (silver) filling for posterior teeth when a composite (tooth colored) filling is used. There will be an extra charge on full gold crowns and implant crowns. In addition, procedures that are cosmetic are not covered by your contract and you will be responsible for payment in full. We cannot be responsible for knowing every aspect of your particular policy. *Let me assure you that only services necessary and appropriate for your treatment and care will be performed.* If you have any questions, someone in our office will be happy to assist you. Thank you for your understanding.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

Further, I understand and acknowledge that photographs and images of me may be shown to other patients and doctors for treatment, educational and promotional purposes and I agree to the same.

In an effort to provide all our patients with the best dental care possible, we ask that a 48 hour cancellation notice be given to allow us the opportunity to adjust our schedule and accommodate another patient. Failed appointments and appointments cancelled without 48 hours notice will be charged a $50.00 fee.

I have read the above conditions of treatment and payment and agree to their content.

X_____ Date: _____ Relationship to Patient: _____

Signature of Patient, Parent, or Guardian

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Dr. Marilia Tate, D.M.D.
2030 Patton Chapel Road
Hoover, Alabama 35216
(205) 979-9491 Fax: (205) 979-5439

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.

_____
Please 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 barrier prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify)

_____

_____

_____

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Dental Health History - Confidential -

DENTAL HISTORY

PATIENT'S NAME: _____

DATE OF LAST DENTAL EXAM / X-RAY: _____

REASON FOR TODAY'S VISIT: _____

CHECK (✔) IF YOU HAVE HAD PROBLEMS WITH ANY OF THE FOLLOWING:

- ❑ BAD BREATH
- ❑ BLEEDING GUMS
- ❑ CLICKING OR POPPING JAW
- ❑ FOOD COLLECTION BETWEEN TEETH
- ❑ GRINDING TEETH
- ❑ LOOSE TEETH OR BROKEN FILLINGS
- ❑ PERIODONTAL TREATMENT
- ❑ SENSITIVE TEETH
- ❑ SORES OR GROWTHS IN YOUR MOUTH

ARE YOU HAPPY WITH YOUR SMILE? Y N WOULD YOU LIKE TO HAVE WHITER TEETH? Y N DID YOU WEAR BRACES BEFORE Y N

HOW OFTEN DO YOU FLOSS? _____ HOW OFTEN DO YOU BRUSH? _____

MEDICAL HISTORY

PHYSICIAN'S NAME: _____ DATE OF LAST VISIT: _____

ARE YOU CURRENTLY UNDER PHYSICIAN CARE? Y N PLEASE DESCRIBE: _____

HAVE YOU HAD ANY SERIOUS ILLNESSES OR OPERATIONS? Y N IF YES, DESCRIBE: _____

(WOMEN) ARE YOU PREGNANT? YES ❑ NO ❑ NURSING? YES ❑ NO ❑ TAKING BIRTH CONTROL YES ❑ NO ❑

CHECK (✔) IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

- ❑ ANEMIA
- ❑ ARTHRITIS, RHEUMATISM
- ❑ ARTIFICIAL HEART VALVES
- ❑ ARTIFICIAL JOINTS
- ❑ ASTHMA
- ❑ BLOOD DISEASE
- ❑ BLOOD TRANSFUSION
- ❑ CANCER
- ❑ CHEMICAL DEPENDENCY
- ❑ CHEMOTHERAPY
- ❑ CIRCULATORY PROBLEMS
- ❑ CORTISONE TREATMENTS
- ❑ DIABETES
- ❑ EPILEPSY
- ❑ FAINTING
- ❑ GLAUCOMA
- ❑ HEADACHES
- ❑ HEART MURMUR
- ❑ HEART PROBLEMS
- ❑ HEMOPHILIA
- ❑ HEPATITIS
- ❑ HIGH BLOOD PRESSURE
- ❑ HIV / AIDS
- ❑ JAW PAIN
- ❑ KIDNEY DISEASE
- ❑ LIVER DISEASE
- ❑ MITRAL VALVE PROLAPSE
- ❑ NERVOUSNESS
- ❑ PACEMAKER
- ❑ RADIATION TREATMENT
- ❑ RESPIRATORY DISEASE
- ❑ RHEUMATIC FEVER
- ❑ SHORTNESS OF BREATH
- ❑ STROKE
- ❑ SWELLING OF FEET OR ANKLES
- ❑ THYROID PROBLEMS
- ❑ TUBERCULOSIS
- ❑ ULCER
- ❑ VENEREAL DISEASE

ALLERGIES

- ❑ LATEX
- ❑ CODEINE
- ❑ LOCAL ANESTHETIC
- ❑ PENICILLIN
- ❑ OTHER _____

PLEASE LIST ANY MEDICAL CONDITIONS NOT LISTED ABOVE

_____

_____

_____

PLEASE LIST CURRENT MEDICATIONS: _____

_____

_____

_____

_____

NOTES: _____

_____

_____

_____

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 PATIENT'S) HEALTH. IT IS MY RESPONSIBILITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES IN MEDICAL STATUS.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN X _____ DATE: _____