Welcome To **Keystone Dentistry**

Date ___/___/___

Thank you for taking time to complete this form for our records!

PATIENT INFORMATION

Last Name _____ First Name_____ MI____
Date of Birth _____/_____/_____ SSN ____-____-_____ Gender: M ___ F ___
Address _____ Apt #_____
City _____ State _____ Zip Code _____
Home Phone (____) ____ - _____ Work Phone (____) ____ - _____ Ext_____
Cell Phone (____) ___ - _____E-Mail Address _____
Employer's Name_____
If Married Spouse's Name _____

WE'RE HAPPY YOU CHOSE US! HOW DID YOU SELECT US?

Doctor or Staff Referral Who? _____
Personal Referral Who? _____
Location? ___ Yes ___ No Other, please tell us more_____

FINANCIALLY RESPONSIBLE PARTY

Last Name _____ First Name _____MI_____
Date of Birth _____/_____/_____ SSN ____-____-_____Gender: M _____ F____
Home Address _____ Apt # _____
City _____ State _____Zip Code _____
Home Phone (____) _____ - _____ Work Phone (_____)____ - _____ Ext _____
Cell Phone (____) ___ - _____E-Mail Address _____
Employer's Name _____

EMERGENCY CONTACT
Person outside of immediate family to contact in case of emergency

Name _____Phone (___) ____ - _____
Relationship _____

INSURANCE INFORMATION

Name of Insured_____ Insured's SSN ____ - ____ - _____
DOB ____/____/____ Group Number _____
Insured's Employer_____
Insurance Company _____Phone (___)____- _____
Address _____City _____ State ____ Zip _____
Patient's relationship to Insured _____

Name of Insured_____ Insured's SSN ____ - ____ - _____
DOB ____/____/____ Group Number _____
Insured's Employer_____
Insurance Company _____Phone (___)____- _____
Address _____City _____ State ____ Zip _____
Patient's relationship to Insured _____

PATIENT MEDICAL AND DENTAL HISTORY

Please circle any of the following that you are now or have been treated for in the past.

Alcoholism	Excessive Bleeding	Pacemaker
Anemia	Fainting	Parkinson's Disease
Arthritis	Glaucoma	Radiation Treatment
Artificial Heart Valve	Growths	Respiratory Problems
Artificial Joints	HIV	Positive Rheumatism
Asthma	Hay Fever	Sickle Cell Disease
Autism	Head Injuries	Sinus Problems
Blood Disease	Heart Disease	Stomach Problems
Blood Transfusion	Heart Attack	Stroke
Bruise Easily	Heart Murmur	Thyroid Problem
Cancer	Heart Surgery	Tuberculosis
Cerebral Palsy	Hemophilia	Tumors
Chest Pain (Angina)	Hepatitis	Ulcers
Depression	High Blood Pressure	Venereal Disease
Diabetes	Immune System Disorders	Other:
Dizziness	Jaundice	_____
Down Syndrome	Kidney Disease	
Drug Addiction	Liver Disease	_____
Emphysema	Mitral Valve Prolapse	
Epilepsy	Nervous Disorders	_____

Are you currently pregnant or suspect you may be pregnant now? Yes ( ) No ( )

Please provide any additional information that would be helpful to know about any items circled above

_____

_____

Please circle or note any allergies or sensitivities you have

Aspirin Barbiturates Codeine Latex Peanuts Penicillin Sulfa

Other: _____

	YES	NO
Are you currently under medical care at this time?	( )	( )
Have you been hospitalized in the last 5 years?	( )	( )
Are you taking any medications at this time? Please list below.	( )	( )
Have you had orthodontic treatment?	( )	( )
Do you clench or grind your teeth?	( )	( )
Have you had prolonged bleeding after surgeries or lacerations?	( )	( )
Do you frequently have a bad taste in your mouth?	( )	( )
Do you use any form of tobacco? (Please list type below)	( )	( )
Do you frequently have a dry mouth?	( )	( )
Are you concerned about bad breath?	( )	( )
Are you concerned about snoring?	( )	( )
Do you wear a mouthguard while participating in sporting events?	( )	( )

When did you last receive your last professional dental cleaning? _____

Rank Your Smile from 1 to 10 (10 = Best / 1 = Worst) _____

Other Medical or Dental Concerns (past or present)

_____

List medications you are currently taking, including aspirin or vitamins/supplements:

_____

_____

_____

FINANCIAL POLICIES

Insurance

Dr. Terry L. Myers, DDS, Inc. ("Keystone" or "We") must receive accurate insurance information at the time of the appointment. If not, patient(s) or the financially responsible party for the patient ("You" or "Your") are required to pay in full for fees when services are rendered. You will also be required to pay in full for fees when services are rendered if your insurance carrier refuses to grant assignment of benefits to Keystone. You are responsible for paying deductibles and co-payments before or at the time of service. Actual amounts received from insurance plans may vary greatly from any estimate of benefits we may provide You. Regardless, You are responsible for paying all charges not covered by Your primary insurance plan. If the accuracy of any such estimate will impact Your decision as to the acceptance of a treatment proposal, You are encouraged to contact Your dental insurance carrier for any clarification from them before beginning treatment. We will submit a primary insurance claim for You up to two times per appointment. Any further insurance appeal becomes Your responsibility. Except for deductibles and co-payments, **You are responsible for payment in full the sooner of: (A) when insurance makes payment on Your claim; and (B) 60 days from the date services are provided even if the insurance company has not paid.**

If we refer you to another health professional please note that we do not take responsibility for nor do we maintain information as to the status of Your insurance plan with referring doctors (i.e. we don't know if they are considered in-network, out of network, etc. with your insurance plan(s)). **If this will impact Your decision as to the acceptance of treatment with them, You are encouraged to contact Your dental insurance carrier for any information and clarification You may need before beginning treatment. We are not responsible for any amounts You may owe other health professionals.**

Payment Terms and Other Issues

Full payment of fees is due before or at the time of service is rendered unless insurance filings are involved as described above. Payments can be made by cash, check or various charge cards accepted by Keystone. **Finance charges on account balances due to Keystone accrue at a rate of 1.5% per month and are compounded each month that an account balance due Keystone remains.** However, when insurance is filed, finance charges may be waived for the period that is the lesser of: (A) the time it takes to receive such insurance proceeds; and (B) 60 days from the date services are rendered. This monthly finance charge rate is subject to change without notice, but will not exceed rates allowed under applicable law.

A service charge for returned checks will be assessed. Currently this fee is $30 and may change from time to time without notice. You may also be responsible, up to limitations set by law, for fees charged by collection agencies or attorneys in situations where they are involved in the collection of account balances.

A service charge for failed appointments and appointments not cancelled with 24 business hours will be assessed. Currently this fee is $35 and may change from time to time without notice.

Acknowledgement and Agreement

As the patient and / or the financially responsible party for the patient, I certify that I have read, understand, and agree to all terms of this Financial Policy. I further understand that a photo static copy of this form shall be considered as effective and valid as an original. I will hold Keystone or any of its employees harmless for any omissions I have made in completion of information. I authorize Keystone to release information regarding my treatment for purposes of filing for potential payment of benefits when applicable and I grant assignment of any such proceeds to Keystone.

_____ _____ _____

Financially Responsible Person Signature | Name Printed | Date