

PATIENT INFORMATION

PLEASE PROVIDE I.D. & DENTAL INSURANCE CARDS TO FRONT DESK

*Please rate your pain currently 0-10, (10 worst) 0 1 2 3 4 5 6 7 8 9 10

Patient Name:	so) General Dentist:			
(If P.O. Box, please give street address al	50)			
Address:				
City:	State: Zip:	E-Mail:		
Home Phone:	Work:	Cell:		
SSN:	Date of Bin	rth:		
Employer:	Address:			
Marital Status:	Spouse:	Phone:		
Spouse's Employer/Address:		Emp. Phone:		
EMERGENCY Contact:	Phone:	Rel	to pt:	
RESPONSIBLE PARTY INFORMA NAME:				
Address: Home Phone:	Work Phone:	Cell:		
Place of Employment ***** Relationship to patient				
PRIMARY DENTAL INSURAN	CE COMPANY:			
Policy Holder's Name:	E	Birthdate:	SSN:	
Employer:	1	Relationship to Patient:		
Group # :	Individual I D # :	Ins. Phone # :		
Ins. Address:	City:	State:	Zip:	
SECONDARY DENTAL INSUR	ANCE COMPANY:			
Policy Holder's Name:	E	Birthdate:	SSN:	
Employer:	Relationship to Patient:			
Group # :	Individual I D # :	Ins. Phone # :		
Ins. Address:	City:	State:	Zip:	

I hereby authorize release of any information regarding my own or my dependant's dental claims and I authorize payment of my insurance benefits directly to D. K. Fagundes, D.M.D., M.S., P.C. for any claims submitted for work performed by Dr. Fagundes for me or my dependants.

D. K. Fagundes, D.M.D., M.S., P.C.

OFFICE PAYMENT POLICY

Payment is expected at the time of service for any amounts not expected to be covered by your insurance. We will file DENTAL insurance claims as a courtesy to you. The amount we collect as a co-pay is an **ESTIMATE.** You are responsible for any balance due after your insurance has paid. <u>The patient, not the insurance company, is responsible for the payment of fees for our services.</u>

I will pay today by: cash ____ check ____ Debit/Credit Card ___ Care Credit ____ Other _____

I have read and understand the payment policy. I understand that the responsibility for payment for dental services provided in this office for myself or my dependents is mine. I agree to pay all collection agency fees,(33,33%), attorney fees and/or court costs associated with the process of collecting a delinquent account. Any account over 30 days past due will be assessed a monthly billing charge equal to $1 \frac{1}{2}$ % of the unpaid balance (18% annually).

You agree, in order for us to service your account or to collect monies you may owe, D K Fagundes, DMD, MS,PC, and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I,, have received a copy of this office's Notice of (please print name)	Date		
NOTICE OF PRIVACY PRACTICES (You may refuse to sign this acknowledgement) I,, have received a copy of this office's Notice of (please print name)	***		
(You may refuse to sign this acknowledgement) I,, have received a copy of this office's Notice of (please print name)			
(please print name)			
(please print name)			
Privacy Practices.			
Detient's Signature: V			
Patient's Signature: <u>X</u> Date:			
EOD OFFICE USE ONLY			

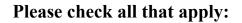
FOR OFFICE USE ONLY

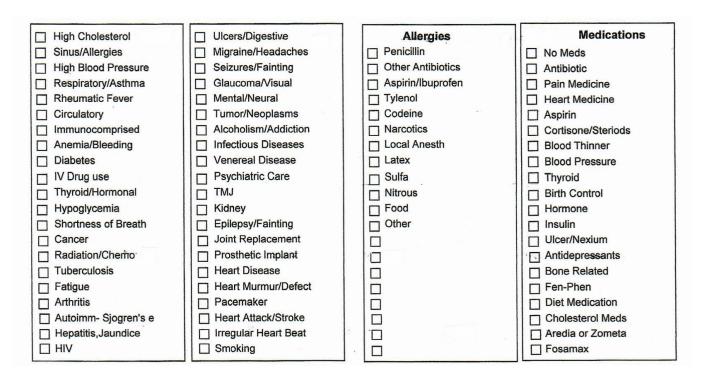
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ___ Individual refused to sign
- ___ Communications barriers prohibited obtaining the acknowledgement
- ____An emergency prevented us from obtaining acknowledgement
- ___ Other (Please Specify) _____

D. K. Fagundes, D.M.D., M.S., P.C. Patient Medical History

1. Has there been any change in your general health within the past year? Please specify	Yes	No
2. Are you under the care of a physician for a current problem?	Yes	No
3. Have you been hospitalized within the past five years?	Yes	No
4. Are you taking any medications or drugs?	Yes	_ No
5. Do you take aspirin?		_ No
6. Have you received therapy for alcoholism or drug addiction during the past five	years? Yes	No
7. Have you ever had any ALLERGY OR ADVERSE REACTIONS to anestheti medications? (if yes, please mark on reverse side of this form)		
8. Have you had abnormal bleeding with previous extractions, surgery, or tra	auma?. Yes_	No
9. Have you ever required a blood transfusion? If so, please explain:Year:Year:Year		No
10. Have you ever had surgery and /or radiation? Yes No When/W	ˈhy:	
11. Date of your last physical exam:		
12. Do you use tobacco products? How long? How much j	per day?	
13. Have you ever taken any of the following drugs: Fen-Phen (Fenfluram Zometa or Fosamax?		
14. Do you have a heart condition (mitral valve prolapse, etc.), an artificial jarrequires you to pre-medicate with antibiotics prior to dental treatment?		
Reason:		
Women:		
15. Are you, or do you think you may be, pregnant?		
16. Are you nursing?		
IF YES, be advised that if you take antibiotics, an alternate method of b		





18. Do you have any disease, condition, or problem not listed above? Yes No If yes, please specify:

All the above information is complete and true to the best of my knowledge. I understand that it is my responsibility to inform the dental office of any changes in my medical status, or that of my dependants.

Date: