Patient Information

Patient Name: ______________________________ Date: __________

Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other __________

Social Security #: __________________ Birth Date: __________________

Phone (Home): __________ (Cell): __________ (Work): __________ Ext: ______

Best time to call: __________________

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: ______________________________

Street Apartment #

____

City State Zip Code

Health Information

Date of Last Dental Visit: __________ Reason for this visit: __________

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV+
☐ Allergies __________ __________
☐ Anemia
☐ Arthritis
☐ Artificial Bones/Joints
☐ Artificial Valves
☐ Asthma
☐ Blood Disease
☐ Blood Transfusion
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Heart Surgery
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date: __________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Local Anesthetic Allergy
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ __________
☐ __________

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Have you ever been previously diagnosed with periodontal disease? ☐ Yes ☐ No
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Name of Physician: ______________________________ Phone: __________
- Have you ever taken any medications for Osteoporosis? ☐ Yes ☐ No
- Are you currently taking any Blood Thinners (Aspirin, Coumadin, Etc.)? ☐ Yes ☐ No
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Current List of Medications: ______________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

______________________________ Date: __________

Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Patient Name ______________________________

☐ Post Card In Mail ☐ Money Mailer ☐ Internet ☐ Insurance ☐ Other ______________________________

Preferred Method To Contact You

Please mark all that apply:

☐ Phone Call ☐ Text Message ☐ Email Address: ______________________________

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ______________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ____________

Social Security #: ____________ Birth Date: ____________

Phone (Home): ____________ (Work): ____________ Ext: ______ Best time to call: ____________

Address: ______________________________
Street Apartment #

____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ____________ Occupation: ____________

Address: ______________________________
Street City State Zip Code

Emergency Contact Person

Name: ______________________________ Phone: ____________

Insurance Information

Primary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ______________________________
Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Insurance Plan Name and Address: ______________________________

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Secondary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ______________________________
Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Insurance Plan Name and Address: ______________________________

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Health Questionnaire Acknowledgment and Consent to Proceed

I certify the answers to the health questions are accurate and correct to the best of my knowledge. Since a change in medical condition and medications can effect treatment. I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Torghele and/or such associate as he/she may designate to perform those procedures as may deemed necessary or advised to maintain my dental health or the dental health of any minor or other individual for whom I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agents(s), including those related to restorative, palliative, therapeutic, or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but ar not limited to, bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness, and muscle soreness. I understand that it is possible for needles to break during the administration or local anesthetic and that surgical recovery of the needle may be necessary.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative, treatment procedure in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

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

______________________________ Date: ____________ Relationship to Patient: ____________
Signature of patient, parent or guardian

______________________________ Date: ____________ Relationship to Patient: ____________
Signature of guarantor of payment/responsible party

Torghele Dental Center Financial Policy

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve. This will allow you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment. We are always available to answer or assist you in any way we can.

To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to financial arrangements regarding their dental treatment.

Optional Payment Terms (If payments are needed, arrangements are required prior to treatment):

1. We accept: Cash, Checks, Visa, Master Card, Discover, and American Express.
2. Full Payment Cash Discount: We offer a 10% discount for all treatment that is paid in full at the time of service for patients without dental insurance.
3. In Office Dental Plan: We offer a Discount Plan to all our patients who don't have dental insurance. This plan provides a 35% discount for all treatment paid at time of service or a 25% discount if payment plan is needed. Certain terms and conditions apply.
4. 90 Day No Interest Payment Option: We can split your out of pocket expense up into 3 equal payments, over a 90 day grace period, and no interest will apply.
5. Care Credit: Offers 6-12 months no interest options O.A.C. There are 4 easy ways to apply: (1) apply online Carecredit.com (2) call (800)365-8295 (3) Use the Quick Response code on the Care Credit brochure with your smart phone. (4) You may fill out Care Credit application here in our office and we would be happy to help you apply.

For those of you with dental insurance, we are happy to bill your insurance for you as a courtesy. It is ultimately your responsibility to keep track of your own insurance payments, benefits, and exclusions. We cannot guarantee your insurance will or will not pay for any services performed. For services not covered by your insurance plan you be liable for dentist full Usual and Customary fee. We work with literally thousands of insurance companies and benefits change all the time. We gather the most up-to-date information as possible from your insurance company and offer you an educated **estimate only**. It is impossible to give you a guaranteed quote, just as it is impossible for your insurance company to guarantee payment. If your insurance does not pay within 90days, **Torghele Dental Center** reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between you and your insurance company, our office is not, and cannot be part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

_____ INITIAL

All accounts including payment plans administered by Torghele Dental Center/Jeffrey J. Torghele D.M.D., are subject to the following terms and conditions: If no payment from you or your insurance company has been received within 60 days of the date of service a 21% annual interest finance charge will be applied to your account. In the event this account may be turned over to an outside agency for collection, I/we agree to pay all attorney fees, with or without suit, court cost, and a collection agency fee of 40%, which will be added to the outstanding balance of my account.

Payment in Full: Our office requires payment in full at time of service unless payment arrangements have been made prior to your appointment.

Emergency Dental Services: All emergency dental services or any dental services performed without previous financial arrangements must be paid for in cash or credit card prior to services being rendered.

Appointments: We consider your appointment to be reserved just for you. We require a 24-48 hour notice if you are unable to make your reserved appointment time. In the event you miss or do not give us enough time to fill your reserved appointment, you may be charged a Missed Appointment fee.

NSF Checks: Dishonored checks will be charged back to your account with a service fee as charged by our bank. This fee will be a minimum of $50.00.

Declined Credit/Debit Card: In the event your credit or debit card payment declines while you are on an agreed upon payment plan, we may charge a $5.00 processing fee until full agreed payment is received.

In Office Plan Enrollment Fee: If no credit or debit card can be provided for us to run your Enrollment Fee monthly, a $5.00 monthly fee will be add to your account until Enrollment Fee is paid in full.

In Office Plan Delinquent Enrollment Fee: If full Enrollment Fee/missed **ANY** monthly payment, Dr. Jeffrey J. Torghele, D.M.D. has the right/will add the full Usual & Customary fees for all services that were provided & completed up to the date you enrolled on the In Office Dental Plan.

Late Fee: If your payment plan falls delinquent a $5.00 monthly late fee may apply.

I have read and understand the financial policy regarding: Payment Terms, Insurance Benefits, and additional fees that may apply to Torghele Dental Center/Jeffrey J. Torghele, D.M.D. I authorize Torghele Dental Center to release financially identifiable information, treatment descriptions, and information either electronically, by facsimile, or paper form to my insurance carrier or any entities that require such information to be submitted. I authorize Torghele Dental Center to send me emails & text messages regarding my appointment(s)/account information.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits more pleasant, please don't hesitate to ask one of our staff members.

Date: ____________ Patient Name: ______________________________________

Signature of Patient/Guardian: ____