GENTLE TOUCH FAMILY DENTISTRY

Eric Palmer DDS

PATIENT INFORMATION

Full Legal Name:_____ I Prefer To Be Called:_____

Date Of Birth: _____/_____/_____ Gender: M F SSN:_____

Marital Status: Child Single Married Divorced Widowed

Phone Number: ( ) _____ - _____ Landline or Cell Phone

Work Phone: ( ) _____ - _____ Employer _____

Can We Send Text Messages? Yes No Email Address _____

Physical Address: _____ City_____ State_____Zip_____

Mailing Address (if different): _____ City_____ State_____Zip_____

How did you hear about us? _____

Emergency Contact Name_____ Emergency Contact Phone ( ) _____ - _____

Emergency Contact Relationship To Patient _____

SPOUSE INFORMATION or FINANCIALLY RESPONSIBLE PARTY

Full Legal Name:_____ Relationship To Patient :_____

Date Of Birth: _____/_____/_____

Phone Number: ( ) _____ - _____ Landline or Cell Phone

Work Phone: ( ) _____ - _____ Employer_____

Physical Address: _____ City_____ State_____Zip_____

Mailing Address (if different): _____ City_____ State_____Zip_____

I certify that all information listed above is accurate to the best of my knowledge. I understand it is my responsibility to notify the office of any changes in my information.

Name (Print)_____ Signature_____

If patient is a minor, Parent or Guardian Signature _____

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DENTAL INSURANCE INFORMATION

If you have any form of Dental Insurance Coverage or Dental Benefit System, and expect your dental benefits to be payable, you **MUST** provide all needed insurance information to the front desk in a timely manner. Please present your insurance card or electronic proof of insurance previous to your appointment if possible.

NECESSARY INSURANCE INFORMATION

1) Insurance Company Name. 2) Name of Policy Holder. 3) Birthday of Policy Holder. 4) ID# or SSN# of Policy Holder.

If you fail to provide all needed Dental Insurance information, the patient or their guardian will be responsible for full treatment cost on the day treatment is rendered.

TIPS: If you do not have access to your dental insurance information, contact your insurance provider (ex. Employer HR Office) and request the insurance company name and a customer service phone number for your Insurance Carrier.

INSURANCE PAYMENT POLICY

I understand that any services rendered from Gentle Touch Family Dentistry that are billable to insurance, will be submitted to the appropriate insurance policy using any information that has been provided.

I understand that the insurance policy is a contract between the policyholder and the insurance company and it is the responsibility of the patient to understand the insurance benefits and limitations specific to their insurance policy.

I agree to pay the estimated patient's portion for treatment at time of service. I understand that I am financially responsible for all unpaid charges, regardless of insurance payment limitations. I authorize the release of information necessary to secure payment of benefits.

I have read and agreed to all terms and conditions listed above.

Name (Print)_____ **Signature**_____

If patient is a minor, Parent or Guardian Signature _____

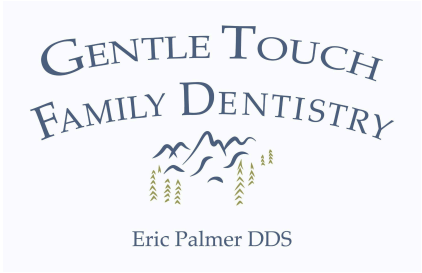
APPOINTMENT CANCELLATION/RESCHEDULING POLICY

I agree to provide **48 hours notice** if cancellation or rescheduling of my appointment is needed. I understand failure to provide appropriate notice will result in a fee being charged. I understand that the fee varies depending on appointment type. Failure to provide appropriate notice for any routine dental care appointment will incur a $50.00/hour late cancellation fee. Failure to provide appropriate notice for an appointment set with the doctor to complete previously discussed dental treatment has an increased fee to $125/per hour. I understand that dismissal from the office may occur after two broken appointments.

I have read and agreed to all terms and conditions listed above.

Name (Print)_____ **Signature**_____

If patient is a minor, Parent or Guardian Signature _____



MEDICAL HISTORY & PRIVACY AGREEMENT

Full Legal Name:_____

Please circle Yes or No for all conditions that apply to you:

Heart Attack	Yes	No	High Blood Pressure	Yes	No	Artificial Heart Valve	Yes	No
Heart Disease	Yes	No	Pacemaker	Yes	No	Excessive Bleeding	Yes	No
Stroke	Yes	No	Diabetes	Yes	No	Asthma	Yes	No
Tobacco Use	Yes	No	Alcohol Dependency	Yes	No	Kidney Problems	Yes	No
Osteoporosis	Yes	No	Drug Dependency	Yes	No	Tumors or Cancer	Yes	No
Tuberculosis	Yes	No	Autoimmune Disorder	Yes	No	Epilepsy	Yes	No

Other Not Listed Above/Notes:

_____

_____

Are you pregnant? Yes No If yes what is your due date? ____/____/____

Have you had any hospitalizations in the last two years? _____

If yes what was the date and list reason for stay _____

Please list any medications taken on a regular basis and why:

_____

_____

Please list any allergies you have:

_____

I certify that all medical information listed is correct to the best of my knowledge. I understand it is my responsibility to notify the office if there are any changes in my information.

Name (Print)_____ Signature_____

If patient is a minor, Parent or Guardian Signature _____