FRANKLIN PERIODONTICS — DON D. FRANKLIN D.D.S., M.S.

Patient Name: _____ **Date:** _____
Last, First MI (Preferred Name)

Gender: ___ **Status:** **Single Married Divorced Other** **Social Security #:**_____
(CIRCLE ONE)

Birth Date: _____ **Phone (H):**_____ **(C):** _____

Address:_____
Street City State Zip Apartment #

Email: _____

Employer: _____ **Work Phone:** _____

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

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

- ☐ HIV
- ☐ Allergies:
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy (current)**
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

Other Allergies:
☐ _____
_____
_____

Please list all current medications: _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- 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: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you smoke? ☐ yes ☐ no If so, how much do you smoke per day? _____

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 doctor at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Name of person or office referring you to our practice: _____

For office use: Health History Reviewed By: _____ Date: _____

PLEASE TURN PAGE OVER TO COMPLETE OVER->

DENTAL INSURANCE INFORMATION (NOT MEDICAL)

Name of Insured:_____ Birth Date: _____
(Self or Spouse or Parent) please circle one

Employer Name: _____ Insurance Carrier: _____

Social Security # or Insurance ID #_____ Group #_____

Insurance Carrier Phone #: _____

Insurance Carrier Address _____

Signature On File Authorization: _____
(patient signature)

I authorize Franklin Periodontics to use my name on any claims or documents that relate to Dental Insurance benefits due to me and my dependents. I authorize the release of any information related to any claims to all my Dental Insurance Companies. I authorize Franklin Periodontics to act as my agent in helping me obtain payment from my Dental Insurance Companies. I authorize payment of Dental Benefits otherwise payable to me directly to Dr. Franklin. I permit a copy of this authorization to be used in place of an original. Signature on file is valid until I notify Franklin Periodontics in writing to cancel.

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship: _____

Phone: (H):_____ (C): _____ (W): _____

Address: _____

I authorize the staff of Franklin Periodontics to act on my behalf in the event I am unable to give consent to administer emergency medical treatment and or contact/summon emergency medical services to administer emergency medical treatment. I also authorize that my emergency contact listed above be contacted if necessary. I have been given opportunity to read and receive a copy of this office's Notice of Privacy Practices.

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash or credit card at the time services are performed.

Patients who carry dental insurance understand that our relationship is with the patient not the insurance company. Please note that this dental office cannot render services on the assumption that our charges will be paid by an insurance company. A pre-treatment estimate may be requested to determine an estimate of the patient's coordination of benefits. The patient or guardian is personally responsible for payment of all services. This office will ESTIMATE the patient's co-insurance (which is due at time of or prior to treatment) and submit insurance claim forms for reimbursement of the balance to be applied to patient account. **Patient is fully responsible for payments not reimbursed by insurance company that have either denied services performed or delayed payment greater than 60 days. 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. A finance charge of 2% per month (24% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied**.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or as per written agreed upon financial agreement. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I understand that Dr. Franklin reserves the right to charge for missed appointments.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. **A charge of $75.00 or $150.00 (depending on the type of appointment) will be billed for appointments broken without 48 hours advance notice. If you are more than 15 minutes late, you will be asked to reschedule your appointment and pay for the $75 late/missed appointment fee.**
I have read the above conditions of treatment and payment and agree to their content.

I am aware that a copy of this office's Notice of Privacy Practices is posted at the front desk for my review.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian, guarantor of payment

_____ Date: _____ Relationship to Patient: _____
Signature of parent or guarantor if patient is a minor