



W
E
L
C
O
M
E



Today's Date ____ / ____ / ____

Please fill out this form completely; front and back. The better we communicate, the better we can care for you.

Patient Information

First Name _____ M.I. _____ Last Name _____

Birthdate ____ / ____ / ____ Social Security # _____ Email _____

Home Address _____ City/State/Zip _____

Home # _____ Work # _____ ext. _____ Cell # _____

Employment Information

Place of Employment _____

Employer's Address _____ Phone _____

Spouse Information

His/Her Name _____ SS# _____ Birthdate ____ / ____ / ____

Employer _____ Work # _____

Emergency Contact Information

Name _____ Relationship _____ Phone _____

If Patient is a Dependent

Is he/she a full time student? ☐ Yes ☐ No

Name and City of School _____

Father's Name _____ Employer _____

Father's Work # _____ ext. _____

Mother's Name _____ Employer _____

Mother's Work # _____ ext. _____

Person Responsible for Account

Name _____

Billing Address _____

Home # _____ Cell # _____

Work # _____ ext. _____

Birthdate ____ / ____ / ____ SS# _____

Ins. Co. Name _____

Claims Address: _____

Ph# _____

Group# _____

Subscriber's Name _____

Birthdate ____ / ____ / ____

SS# _____

Patient Medical History

Please check ALL the following medical conditions or problems that you currently have or have had in the past.

- | | |
|---|--|
| ☐ Recent Artificial Joints/Bones | ☐ Cancer Chemo Therapy |
| ☐ Artificial Valves | ☐ Congenital Heart Defect |
| ☐ High/Low Blood Pressure | ☐ Diabetes |
| ☐ Arthritis | ☐ Difficulty Breathing |
| ☐ HIV+/AIDS | ☐ Drug/Alcohol Abuse |
| ☐ Blood Transfusion | ☐ Emphysema |
| ☐ Kidney Problems | ☐ Glaucoma |
| ☐ Mitral Valve Prolapse | ☐ Epilepsy/Seizures/Fainting |
| ☐ Psychiatric Conditions | ☐ Fever Blisters/Herpes |
| ☐ Rheumatic/Scarlet Fever | ☐ Heart Attack/Stroke |
| ☐ Severe Frequent Headaches | ☐ Heart Murmur |
| ☐ Sickle Cell Disease/Traits | ☐ Heart Surgery/Pacemaker |
| ☐ Sinus Problems | ☐ Hemophilia/Abnormal Bleed |
| ☐ Venereal Disease | ☐ Hospitalized for any reason within the last 2 years |
| ☐ Hepatitis | ☐ None of the above |
| ☐ Vertigo | |

Are you allergic to any of the following? (Please Check)

- | | |
|---|--|
| ☐ Aspirin | ☐ Jewelry/Metals |
| ☐ Codeine | ☐ Penicillin |
| ☐ Dental Anesthetics | ☐ Other _____ |
| ☐ Erythromycin | ☐ None of the above |

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently under the care of a physician? ☐ Yes ☐ No

Physician's Name _____

Phone # _____

Are you taking any prescription/over-the-counter drugs? ☐ Yes ☐ No

Please List:

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

For Women

Are you currently taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week# _____

Are you nursing? ☐ Yes ☐ No

For those patients with insurance coverage:

I agree to assign to my doctor all dental insurance payments for treatment given to me or a member of my family for whom I am responsible.

I also agree to pay any balance that is not covered by my insurance carrier. I understand that I am responsible for my account, and that the insurance company is responsible to me and not my healthcare provider.

If my insurance carrier pays benefits directly to me, I agree that I will pay my doctor all payments due for services.

For those patients who do not have insurance coverage:

If I do not have dental insurance coverage, I understand that I am financially responsible for all bills incurred during my treatment.

Authorization for release of information

I authorize Dr. David G. Slyby to furnish any professional information necessary for the completion of my insurance claim. Dr. Slyby is hereby released from any legal liability that may arise from the release of the information requested.

If payment has not been received within 30 days from the date of statement a monthly charge of 1.5% (which is an annual rate of 18%) of the balance due or a charge of \$5.00 per statement, whichever is greater, will be added to the amount of your account balance.

I further agree that in the event that the account is not paid in accordance with the office policy, I agree to pay collection costs and reasonable attorney fees if the account is placed in the hands of a collection agency or attorney.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature _____

Date _____

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions, please ask us. We are more than happy to help!



David G. Slyby, DDS
4606-B East State Blvd
Fort Wayne, IN 46815
Tel: 260-484-0725
Fax: 260-483-4847

Insurance Release and Financial Policy

I certify that I have read and understand the questions about my health history. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold David G. Slyby DDS, or any other member of his staff responsible for any errors or omissions that I have made in the completion of this form.

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for Dr. David G. Slyby to provide a dental examination, care, and/or treatment to me or someone I am authorized to make medical decisions for. This evaluation, care, or treatment is considered medically necessary and proper in the diagnosing or treatment of his/her/my physical condition. I understand that even though I give my consent for evaluation, care, or treatment, I may refuse any of these services at any time.

Financial Policy Statement

In consideration of services rendered and to be rendered by Dr. David G. Slyby to the patient named below, I (we) agree to pay Dr. David G. Slyby for all services and charges as are ordered by the attending doctor. We will file your insurance claim as a courtesy for you; however, we are not a contracted provider with any group/individual insurance plans including Affordable Care Act Plans.

I (we) further agree and guarantee that, in the event the account is not paid in accordance with the financial arrangements made by discharge, or within 30 (thirty) days of discharge, I (we) will pay all processing fees, collection costs, and interest at the rate of 18% per year including reasonable attorney fees and court costs if this account is placed in the hands of a collection agency or attorney.

Acknowledgement of Receipt Notice of Privacy (NP)/ Benefit Assignment/ Release of Information

A Notice of Privacy (NP) has been made available to me by David G. Slyby, DDS. The NP describes how my health information may be used or disclosed and my rights under the Health Insurance Portability and Accountability Act (HIPAA). I hereby authorize my insurance company to release all information necessary for the payment of benefits. I hereby assign payment of benefits by my insurance company to Dr. David G. Slyby.

I am giving consent for release of minimal health information or financial information to the following individuals:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
_____	_____	_____
_____	_____	_____

I further authorize David G. Slyby, DDS to communicate with me electronically through the email address provided. I understand that this email is not secured by encryption therefore is not considered a secured or private communication.

Print Patient Name

Date

Signature of Financially Responsible Party (Parent or Guardian)

Date