Stuart R. Douglas DMD, PLLC
Marisa J. Clifford DMD
139 N. Main St. • Cortland, NY 13045 • Ph (607) 753-0602 • Fax (607) 758-8737

Dental Arts Group

Patient Information **Today's Date:** _____

Chart# _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** _____-_____-_____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____
Home Mobile Work Ext Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Responsible Party

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Employer Name: _____

Patient's Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Yellow Pages ☐ Internet ☐ Newspaper ☐ School ☐ Work

☐ Other (name below):

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

Dental History

Former Dentist _____ Date of Last Dental X-rays _____

Reason for today's visit: _____

How often do you brush: _____ How often do you floss? _____

Medical History

Please list all medications you are currently taking: _____

_____

Allergies: _____

(Women) Are you pregnant? _____ Nursing? _____

- ☐ AIDS
- ☐ Artificial Joints Date: _____
- ☐ Blood Thinners
- ☐ Circulatory Issues
- ☐ Epilepsy
- ☐ Head Injuries
- ☐ Heart Problems Describe: _____
- ☐ Jaundice
- ☐ Mental Disorders
- ☐ Pregnancy
- ☐ Sinus Problems
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Cancer
- ☐ Cough, Persistent
- ☐ Excessive Bleeding
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Jaw pain
- ☐ Nervous/Anxiety Disorders
- ☐ Radiation Treatment
- ☐ Stomach problems
- ☐ Tumors
- ☐ Arthritis, Rheumatism
- ☐ Asthma
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Fainting
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Kidney Diseases
- ☐ Other _____
- ☐ Respiratory Problems
- ☐ Stroke
- ☐ Ulcers
- ☐ Artificial Heart Valves
- ☐ Bisphosphonates
- ☐ Chemotherapy
- ☐ Dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ HIV +
- ☐ Liver Disease
- ☐ Pacemaker
- ☐ Rheumatice Fever
- ☐ Thyroid Problems

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. 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 at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate for this dental care can only be extended for a period of siz months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. 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 attorne fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

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

Signature of patient, parent, or guardian (responsible party):

Signature _____ Date _____

Relationship to Patient: _____ Response Date ____/____/_____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Dr. Stuart R. Douglas and/or Dr. Marisa J. Clifford may use my healthcare information and may disclose such information to any insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I consent to all recommended treatment presented by above-name doctors.

Signature _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices

***** You may refuse to Sign this document *****

I, _____, have received and read a copy of this office's Notice of Privacy Practices.

(Please Print Name)

_____

(Signature)

_____

(Date)

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 situation prevented us from obtaining acknowledgement**

_____ **Other (please specify)** _____

Response Date _____/_____/_____