PATIENT INFORMATION

Mr. Miss Mrs. Ms.

Patient's full name _____ Today's Date _____

SS#_____ Birthdate _____ Age_____ Sex_____ Weight_____Ht. _____

Patient's address_____ City_____ State_____ Zip_____

Home phone #_____ Cell phone #_____ Work phone # _____

Whom may we thank for referring you to our office?_____

Person to contact in case of emergency_____ Phone_____

GUARANTOR//PARENT: ❑ Same as above

Guarantor/Parent Name _____ Relationship to patient _____

Address_____ City _____ State_____ Zip_____

Phone_____ Date of Birth _____ Social Security #_____

Employer_____ Employer Telephone_____

INSURANCE TO BILL:

❑ DHW/DQ _____ ❑ Medicaid #_____

❑ Private Insurance (Complete lines below fully):

Primary Insurance Name_____ ❑ Medical ❑ Dental

Subscriber's name_____ Relationship to patient_____

Subscriber's address_____

Social Security #_____ Group #_____ Date of Birth_____

Employer_____ Employer phone #_____

Secondary Insurance Name_____ ❑ Medical ❑ Dental

Subscriber's name_____ Relationship to patient_____

Subscriber's address_____

Social Security #_____ Group #_____ Date of Birth_____

Employer_____ Employer phone #_____

Our fees are due when services are rendered. If other arrangements are necessary, they need to be made before service is rendered. While we will assist you in filing insurance claims, the entire amount of our fees is the patient's responsibility. Any amount failed to pay or contested or denied by the insurance company is between the patient and the insurance company. As part of our analysis of your credit standing, we may request an investigative consumer credit report.

Any patient account unpaid after 60 days from the date of service may be charged interest at the rate of 1.5% per month. In case of failure to pay, we reserve the right to add additional costs like, but not limited to, reasonable collection fees, finance charges, late fees, court costs and attorney's fees. These costs are also the patient's responsibility. Thank you.

Signature of patient: _____

Signature of responsible party (parent/guardian/POA):_____

-PATIENT MEDICAL INFORMATION-

Please circle
Yes or No

1. Has there been any change in your general health in the past year?..... Y/N
2. Are you now under the care of a physician?..... Y/N

   If so, what is the condition being treated?_____
3. Have you had any serious illness or operations?..... Y/N

   If so, what was the illness or operation?_____ Y/N
4. Have you been hospitalized or had a serious illness within the past 5 years?..... Y/N
5. Do you have or have you ever had any of the below diseases or problems?..... Y/N

Sleep Apnea	Asthma	Hepatitis	Hepatitis
Rheumatic Fever	Seizures	Latex Allergy	Stroke
Heart Disease	Diabetes	Stomach Ulcers	
Cardiovascular Disease	Tuberculosis	Kidney Trouble	
Heart Attack	Anemia	Artificial Joints or Hearth Valves	
High Blood Pressure	Heart Arrhythmia	Abnormal Bleeding	

6. Do you have any diseases, conditions, or problems not listed above that you think we should know about…..Y/N
7. Are you HIV positive?_____ Y/N
8. Do you take any blood thinners such as?..... Y/N

Coumadin	Xarelto	Plavix	Pradaxa
Aspirin	Eliquis	Effient	

9. Are you taking any drugs or medications?.,..... Y/N

   If so, please list medications._____

   _____

   _____
10. Are you allergic to any medications?_____ Y/N

    _____
11. Are you pregnant or nursing?_____ Y/N
12. Do you smoke, vape or chew tobacco_____ Y/N

    If yes, for how long?_____
13. Do you use:

Alcohol?	Yes/No	If yes, how often per week?
Marijuana?	Yes/No	If yes, how often per week?
Recreational Drugs	Yes/No	If yes, how often per week?

PHYSICIAN:_____
DENTIST:_____
YOUR CURRENT PHARMACY:_____
REVIEWED BY: DR._____

Form Updated_____
Date/Initials_____

SIGNATURE ON FILE

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____, hereby authorize

_____, to pay and hereby assign directly to William E. Paul, D.D.S., P.C. all medical and dental benefits, if any, otherwise payable to me for services as described on the attached forms. I understand I am financially responsible for all charges incurred less any dental insurance benefits when received by and paid to William E. Paul, D.D.S., P.C.

Authorization is hereby given to release all information necessary to the payment of said benefits.

Authorized Signature of Covered Person/Employee:

X_____ Date_____

926 East LaSalle | South Bend, Indiana 46617-2887 | *ph* 574.233.7700 | 1.800.274.2429 | *fx* 574.233.8264

Authorization Form for Use or Disclosure of Patient Information

William E. Paul, D.D.S, P.C.

Patient Name:_____ Patient's DOB:_____

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Authorization. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information (PHI), and of other important matters about your PHI. A copy of our Notice accompanies this Authorization. We encourage you to read it carefully and completely before signing this Authorization.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice, which will contain the changes. Those changes may apply to any of your PHI that we maintain. I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This authorization expires on the following date, or when the following event occurs: 7 years from your last account activity

You may obtain a copy of our Notice of Privacy Practices at: 926 E Lasalle Ave, South Bend, IN 46614

I understand that I may revoke this authorization at any time by following the directions in the Notice of Privacy Practices. I understand that my revocation must be in writing. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

Signature of Patient or Patient's Personal Representative:

_____Date_____

If Personal Representative:

Print Name:_____

Relationship to Patient:_____

Please list any individual you feel we are able to disclose medical and financial information:

Name	**Relationship**	**Phone Number**

William E. Paul, DDS, PC - 926 East LaSalle

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I,_____have been informed of this office's Notice of Privacy Practices.

_____

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 acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____