WELCOME TO BISHOP FAMILY DENTAL

Thank you for selecting our dental office! We will strive to provide you with the best possible dental care. To help us meet your dental health needs, please fill out this form completely.

PATIENT INFORMATION

Last Name_____ First Name _____M.I. ____
Sex: ◯Male ◯Female ◯ Married ◯Single ◯Child ◯Widowed ◯Divorced
Birth date_____ Social Security #_____
Home Address_____
City _____ State _____ Zip _____
Home Phone _____Cell Phone_____
Patient Employer_____ Work Phone_____
Email Address_____
Emergency Contact_____ Phone _____
Contact preference (check all that apply)☐Email☐Text☐Other _____

REFERRAL INFORMATION

Where did you first hear about us?_____
Whom may we thank for referring you? _____
Have you seen or heard about us from any of these places? (Please check all that apply.)
☐Internet ☐Friend ☐Patient ☐Yellow pages ☐Doctor referral ☐Insurance
☐City Deals☐Living Social☐Amazon Locals☐Groupon☐Other_____

RESPONSIBLE PARTY

Responsible for account _____ Relation to patient _____
Birthdate_____Social Security #_____
Address_____
City _____ State _____ Zip _____
Home Phone _____Cell Phone_____
Employer _____ Work Phone _____

DENTAL INSURANCE INFORMATION

Subscriber Name_____ Birth date _____
Address (if different)_____
Relationship to patient_____Social Security #_____
Dental Insurance Provider_____Phone_____
Address _____ Subscriber ID # _____
Employer _____ Group Policy # _____

ADDITIONAL DENTAL INSURANCE INFORMATION

Subscriber Name _____ Birth date _____
Address (if different)_____
Relationship to patient _____ Social Security #_____
Dental Insurance Provider _____ Subscriber ID # _____
Employer _____ Group Policy # _____

Please continue this form on the reverse side.

PATIENT HEALTH HISTORY

Yes No

1. Have you been under a physicians care or had any health problems in recent years?
   If yes, explain

   _____

   _____

   Physician's name:_____ Phone: _____

2. Please list name and purpose of any medications you currently take _____

   _____

   _____

3. Have any allergies? ☐ Latex, ☐ Antibiotics, ☐ Metal, ☐ Local Anesthetic, ☐ Sulfa, ☐ Codeine

Other (explain) _____

4. (Women) Are you pregnant?
5. Do you have any pain now? _____
6. Are you interested in cosmetic procedures (bleaching, veneers)?
7. Are you interested in braces or Invisalign (adults and youth)?
8. Do you have a history of gum disease? _____
9. Do you want missing teeth replaced? _____
10. When was your last dental visit? _____
11. Other information the dentist should know _____
12. Have you ever taken Bisphosphonates for Cancer treatment or Osteoporosis?
13. Have you ever taken any of the group of drugs referred to as "fen-phen"?

Do you have or have you had any of the following?

Yes	No		Yes	No		Yes	No	
◯	◯	AIDS/HIV	◯	◯	Emphysema	◯	◯	Radiation Treatment
◯	◯	Anemia	◯	◯	Epilepsy	◯	◯	Respiratory Disease
◯	◯	Arthritis, Rheumatism	◯	◯	Fainting or dizziness	◯	◯	Rheumatic Fever
◯	◯	Artificial Heart Valves	◯	◯	Glaucoma	◯	◯	Scarlet Fever
◯	◯	Artificial Joints	◯	◯	Hay Fever	◯	◯	Shortness of Breath
◯	◯	Asthma	◯	◯	Headaches	◯	◯	Sinus Trouble
◯	◯	Back Problems	◯	◯	Head Injuries	◯	◯	Skin Rash
◯	◯	Bleeding abnormally, with extractions or surgery	◯	◯	Heart Murmur	◯	◯	Special Diet
◯	◯	Blood Disease	◯	◯	Hear Problems	◯	◯	Stroke
◯	◯	Cancer	◯	◯	Hepatitis Type___	◯	◯	Swollen Feet/Ankles
◯	◯	Chemical Dependency	◯	◯	Herpes	◯	◯	Swollen Neck Glands
◯	◯	Chemotherapy	◯	◯	High Blood Pressure	◯	◯	Thyroid Problems
◯	◯	Circulatory Problems	◯	◯	Low Blood Pressure	◯	◯	Tobacco Products
◯	◯	Congenital Heart Lesions	◯	◯	Mental Disorder	◯	◯	Tonsillitis
◯	◯	Cortisone Treatments	◯	◯	Mitral Valve Prolapse	◯	◯	TMJ/Neck Pain
◯	◯	Cough, persistent/bloody	◯	◯	Nervous Problems	◯	◯	Tuberculosis
◯	◯	Diabetes	◯	◯	Pacemaker	◯	◯	Tumors
◯	◯	Venereal Disease	◯	◯	Psychiatric Care	◯	◯	Ulcer

I hereby certify that my answers to the forgoing questions are accurate. Since a change in my medical conditions or medications can affect dental treatment; I agree to take the responsibility to notify the dentist of any changes at any subsequent appointment.

Signature_____ Date _____

(Patient, legal guardian or authorized agent of patient)

FINANCIAL POLICY

We are committed to providing you with the best care possible. We use the best materials and equipment available, and stay up to date on the latest technology, procedures and techniques through continuing education. Our dental practice is a small business and there are costs associated with providing your treatment. We hope that understanding our financial policy will help to avoid any misunderstandings as we provide for your dental needs. Please help us by providing your insurance information, filling out our Patient Information Form completely and by reading and signing this Financial Policy Agreement.

Warranty

All dental treatment is custom and non-refundable. We guarantee all of our work and will replace anything resulting from technique or material error if you maintain regular 6 month maintenance visits in our office and complete all necessary work. Not doing these things will jeopardize the success of the work we perform. We offer this because we use the best materials and techniques available. We will replace at no cost, any filling that becomes loose or detaches from the tooth within 2 years from the date of placement. For a period of 2 years from the date of service, we will replace at no cost a crown, veneer, or bridge due to breakage, misfit, or decay, and we will replace a crown between 2-5 years old at a 50% discount. We will replace occlusal sealants that become dislodged at no charge for up to 2 years from the date of original placement. If a root canal therapy is not successful, we will perform a re-treatment at no charge within 2 years of the root canal completion date. If attempts at any treatment fail requiring tooth extraction during 2 years past the date of treatment, the cost of the initial treatment will be applied to the fee for tooth replacement. If a patient receives additional treatment by another dentist on a tooth that was initially treated in our office, the warranty will be voided.

The following terms apply regarding payment of your dental fees:

1. You are responsible for your own dental bill. If you have dental insurance, we will bill your insurance and provide all necessary documentation as a courtesy; however, you are ultimately responsible for the charges for all services performed and whether covered by your insurance plan or not.
2. All co-payment quotes given to you by our office based on insurance coverage are only estimates and not guaranteed. Your dental insurance plan is a contract between you, your employer, and your insurance company. Please read and understand your own individual policy and take an active role in communicating with your insurance company to resolve problematic claims.
3. All payments must be made at the time services are rendered. Patients with dental insurance MUST pay 100% of estimated co-payments at the time services are rendered.
4. Not all services are covered by insurance benefits. Patients who elect non-covered procedures are required to pay 100% of those charges at the time the services are rendered.
5. We accept cash, checks, Visa, MasterCard, Discover, and American Express for your convenience.
6. We offer financing with no interest for up to 12 months through Care Credit.
7. A monthly finance charge of 1.5% (18% annually) will be assessed to all account balances older than 90 days.
8. If an insurance claim is still outstanding after 90 days, it is your responsibility to pay the outstanding balance on your account and we will refund the difference if and/or when payment is received from your insurance company.
9. Delinquent account balances over 120 days old are subject to referral to a collection agency upon review. You will be given 10 days notice prior to your account being forwarded to a collection agency. You may contact us during this time to make payment arrangements to stop the collection process.
10. In the event an account is sent to a collection agency, you agree to pay a 40% collection agency fee and any reasonable attorney and court costs.
11. We require a minimum of 24 hour notice for appointment cancellations, $55.00 per hour for missing an appointment. There will be a charge for appointments cancelled or broken without 24 hours advance notice.
12. A $25.00 fee will be charged for copies of dental records.
13. You are entitled to a refund for any credit balance on your account that results from overpayment. The refund will be issued in the form of a check and mailed to you after all outstanding insurance claims have been paid.
14. I assign all insurance benefits to be paid to Dr. Daniel J. Bishop D.M.D., unless already paid by me.
15. By signing below, you acknowledge receipt of this Financial Policy.

Signature_____ Date_____

Name:_____

Relationship to Patient: _____

Witness_____ Date_____

SUBMIT