Horacek Dental 503-254-2068

Date_____

Full Name_____Prefer_____

Address_____

City, State, Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Birth Date_____ Soc Sec_____ Drivers Lic_____

E-mail_____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Other_____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Other

Student Status: ☐ Full Time ☐ Part Time ☐ School

Person to contact in case of emergency_____ Phone_____

How did you hear about us?_____

Responsible Party (if someone other than patient)

Full Name_____ Phone_____

Relationship to patient_____

Primary Insurance Information:

Name of Insured:_____ Insured Soc Sec:_____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other Insured Birth Date:_____

Employer:_____

Insurance Company:_____ Group Number:_____

Insurance Phone:_____ Policy Number:_____

- I authorize my insurance company to pay Horacek Dental all insurance benefits otherwise payable to me of services rendered. I authorize the use of this signature on all insurance submissions.
- I authorize Horacek Dental to release all information necessary to secure the payment of benefits.
- I understand that I am financially responsible for all services provided to me and/or my dependent(s), regardless of insurance payments.
- I agree to pay all late and/or finance charges accrued on my account.
- Insurance is a contract between you and your insurance company. We are not a party to this contract. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your benefits and eligibility. You agree to pay any portion of the charges not covered by insurance.

Signature _____ Date _____

Confirmation and Cancellation Policy

- Our office will call/email/text you 1-2 day before your appointment. Preference_____
- You, the patient, will give our office **24 hours** notice if you need to move your appointment time or day.
- If we do not receive **24 hours** notice, a fee will be charged for **less than 24 hours notice or failed appointment** to offset the preparation and resetting time for your treatment room.
- Remember, each appointment is set aside **exclusively for you or your family members.** Our goal is to be thoroughly prepared for you. Thank you for your understanding.

Signature _____ Date _____

PAST DUE ACCOUNTS: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all the collection costs, which may be incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees, which we incur, plus all the court costs. In case of suit, you agree the venue shall be in Multnomah County, OR. WAIVER OF CONFIDENTIALITY: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

FINANCE CHARGE: A finance charge will be imposed on each past due charge on your account, which has not been paid within sixty days of the time the item was added to the account. The FINANCE CHARGE will be computed at the rate of one and one half percent (1.5%) per month or an ANNUAL PERCENTAGE RATE OF EIGHTEEN PERCENT (18%). The finance charge on your account is computed by applying the periodic rate (1.5%) to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed sixty (60) days ago, and then subtracting any payments or credits to the account during that time. The minimum finance charge is $0.50. If you have insurance, the finance charge will not be applied to outstanding insurance claims.

Medical History

Are you allergic to any of the following?

☐ Aspirin ☐ Acrylic ☐ Codeine ☐ Latex ☐ Local Anesthetic ☐ Metal
☐ Penicillin ☐ Other, Please explain_____

Are you in good general health?_____

Have you been under the care of a Physician within the past two years?_____

Have you ever had a serious illness? If so, what?_____

Have you taken any medications for the following conditions:

☐ Anticoagulants (blood thinners) ☐ Cortisone (steroids) ☐ Osteoporosis
☐ Antidepressants ☐ Heart Condition ☐ Pain
☐ Asthma or Emphysema medication ☐ Hormones or birth control ☐ Thyroid
☐ Blood Pressure ☐ Insulin

List any medications _____

Have you ever had any hospitalizations or surgery? (list)_____

Women: Are you pregnant now? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Do you use tobacco?, If so, how many packs a day?_____

Do you use alcohol? If so, how many drinks per week?_____

Do you use recreational drugs?_____

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

☐ Anemia	☐ Diabetes	☐ Heart Surgery	☐ Seizures
☐ Asthma	☐ Drug Addiction	☐ Hepatitis	☐ Sickle Cell Disease
☐ Artificial Joint	☐ Emphysema	☐ High Blood Pressure	☐ Stomach Problems
☐ Artificial Heart Valve/Stent	☐ Epilepsy	☐ Kidney Problems	☐ Stroke
☐ Arthritis	☐ Fainting Spells	☐ Multiple Sclerosis	☐ Thyroid Disease
☐ Blood Transfusion	☐ Fibro Myalgia	☐ Psychiatric Treatment	☐ Tuberculosis
☐ Cancer	☐ Glaucoma	☐ Radiation Treatment	☐ Venereal Disease
☐ Chest Pain (angina)	☐ Heart Murmur	☐ Rheumatic Fever	☐ Ulcers
☐ Chemotherapy	☐ Heart Pacemaker	☐ Rheumatism	

Financial/Payment Policy

PAYMENTS: Unless we approve other arrangements in writing, **payment is due at the time of service.** If you have insurance, and your insurance payment estimate is less than they actually pay, we will bill you for the remainder. The balance on your statement is due and payable on the date of issue, and is past due if not received within two weeks.

PAYMENT OPTIONS:

- Cash Discount-5% discount for payment in full by cash or check at the time of service if there is **not insurance**
- Pay full patient portion at the time of service. If the procedure requires 2 appointments, pay in full at the first appointment.
- For procedures requiring 2 appointments, pay half of treatment fee at the first appointment and the second half at the final appointment. If you have insurance, pay the half of the estimated portion at the first appointment, and the second half at the final appointment.
- Credit Card Payment Options (with a signed authorization form and established payment history with our office). We allow you to make 3 equal installments: 1/3 payment due at the first appointment, 1/3 due 30 days later and the remaining balance sixty days from the initial appointment. Signed authorization allows office personnel to charge these payments to your credit card on the due dates.
- Care Credit-if you are interested in an extended payment plan, we offer our patients, upon approval, an interest-free term loan (up to 12 months) with no down payment, no annual fee and no prepayment penalty for services over $300. You can apply at www.carecredit.com
- Senior discount-5% discount for services paid by check, 3% for credit card, for age 62 and older if there is no insurance.
- RETURNED CHECKS: There is a fee (currently $25) for any checks returned by the bank.

I acknowledge that I have read, and agree to the above financial terms

Signature_____ Date_____