Generation Dental Group
Julie L. Ring D.D.S.
PATIENT INFORMATION

Patient Name: _____ Preferred Name _____ Male Female
Last First MI (Circle one)

Birth Date: _____ **Social Security #:** _____ Single / Married / Divorced / Child

Phone:Home _____ Cell _____ Work _____

E-Mail:_____

Address: _____
Street Apt # City State Zip Code

Employer Name: _____ Occupation: _____

Insurance Plan Name: _____ Group #_____ Phone #_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE?_____

Date of Last Dental Visit: _____ **Reason for this visit:** _____

HEALTH INFORMATION

PLEASE LIST CURRENT MEDICATIONS YOU ARE TAKING:_____

_____

Do you have or have you had any of the following? Please check YES or NO:

Y	N		Y	N		Y	N		Y	N	
☐	☐	PREMED- Amoxicillin	☐	☐	Arthritis	☐	☐	Head Injuries	☐	☐	Psychiatric Care
☐	☐	PREMED- Clindamycin	☐	☐	Asthma	☐	☐	Heart Disease	☐	☐	Radiation Treatment
☐	☐	PREMED- Other	☐	☐	Blood Disease	☐	☐	Heart Murmur	☐	☐	Respiratory Problems
☐	☐	Allergies- Seasonal	☐	☐	Blood Pressure H IGH	☐	☐	Heart Surgery	☐	☐	Rheumatic Fever
☐	☐	Allergy - Aspirin	☐	☐	Blood Pressure -LOW	☐	☐	Hepatitis	☐	☐	Rheumatism
☐	☐	Allergy- Codeine	☐	☐	Blood Transfusion	☐	☐	Herpes	☐	☐	Scarlet Fever
☐	☐	Allergy- Erythromycin	☐	☐	Bruises Easily	☐	☐	HIV/Aids	☐	☐	Shortness of Breath
☐	☐	Allergy- Food	☐	☐	Cancer	☐	☐	Hypoglycemia	☐	☐	Sickle Cell Anemia
☐	☐	Allergy- Latex	☐	☐	Chemotherapy	☐	☐	Kidney Disease	☐	☐	Sinus Problems
☐	☐	Allergy- Other	☐	☐	Diabetes	☐	☐	Liver Disease	☐	☐	Stomach Problems
☐	☐	Allergy- Penicillin	☐	☐	Dizziness	☐	☐	Lung Disease	☐	☐	Stroke
☐	☐	Allergy- Sulfa	☐	☐	Emphysema	☐	☐	Mental Disorders	☐	☐	Swelling of Feet / Ankles / Hands
☐	☐	Anemia	☐	☐	Epilepsy	☐	☐	Mitral Valve Prolapse	☐	☐	Tuberculosis
☐	☐	Alzheimer's Disease	☐	☐	Excessive Bleeding	☐	☐	Nervous Disorders	☐	☐	Tumors
☐	☐	Artificial Heart Valve	☐	☐	Fainting	☐	☐	Pacemaker	☐	☐	Ulcers
☐	☐	Artificial Joints	☐	☐	Glaucoma	☐	☐	Pregnancy Due Date:_____	☐	☐	Venereal Disease
☐	☐	SMOKE/CHEW									

.• Have you ever had any complications following dental treatment? ☐ Yes ☐ No If yes, please explain: _____

• Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

• Are you now under the care of a physician? ☐ Yes ☐ No If yes, please explain : _____

• **Name of Physician**: _____ **Phone** : _____

• Do you have any health problems that need further clarification? ☐ Yes ☐ No If yes, please explain : _____

In case of emergency, whom shall we call: Name _____ **Relationship** _____

Phone Numbers: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctors at the next appointment without fail.

X_____ Date:_____ **X** _____Date:_____
Signature of patient, parent or guardian **Dentist's Signature**

Generation Dental Group

Responsible Party & Insurance Information

Name: _____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone: Home _____ Work _____ Ext: _____ Cell: _____

Address: _____
Street Apartment # City State Zip Code

Primary Insurance Information

Employer Name & Address: _____

Insurance Plan Name: _____ Group #: _____

Phone Number: _____ Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

CONSENT FOR SERVICES

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or her staff, I agree to pay the reasonable value of said services to said Doctor, or her assignee, at the time said services are rendered, or within five (5) days of billing, unless previous financial arrangements have been made.

All emergency dental services, or any dental service performed without prior financial arrangements, must be paid at the time the services are performed. If I carry insurance, I understand that this office will help prepare my **PRIMARY** insurance forms to assist in making collections from that insurance carrier and will credit such collections to my account.

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. Since it is not possible to coordinate insurance payments from any **SECONDARY INSURANCE CARRIER,** we are unable to accept payment from your secondary insurance. We will be happy to assist you when you file for your reimbursement from that carrier.

A billing charge of 1 ½% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) or $15.00 minimum per month will be charged on the unpaid principal balance (including insurance payments due) on all accounts not paid within 60 days of treatment date. As a courtesy to you we will submit to your dental insurance. If your dental insurance company does not pay after the second submission, you are responsible for payment on your account.

My account will subject to collections if not paid within 60 days, I will be held responsible for all attorney/collection fees incurred from this debt.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

I agree to the above stated conditions and I hereby authorize treatment and direct payment of the dental benefits otherwise payable to me, directly to Dr. Julie L. Ring.

CANCELLATION POLICY

I understand that a minimum of $25.00 will be charged to my account for any appointment cancelled or rescheduled within a 24 hours of my original scheduled appointment time. Any appointment in which I do not arrive for and no notice was given to Dr. Ring there will be a $25.00 (minimum) fee charged to my account. These fees must be paid before any additional appointment can be scheduled. If there are 3 or more appointments cancelled or broken within a 1 year period, Dr. Ring holds the right to no longer see me as a patient.

HIPPA CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of consent: By signing this form, you will consent to your use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the use and disclosures we may make of your protected heath information and of completely before signing this consent. You have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance of this consent before we received your revocation, and that we may decline to treat you, or continue treating you if you are revoked.

X_____ **Date:** _____

Signature of Patient/ Responsible Party / or Guardian