PERRINE & STAUNTON FAMILY DENTISTRY, PLLC

P.O. Box 640 • RIPLEY, WV 25271 (304)372-5725

Patient Name: ______________ ______________ ___ ______________
Last First M Preferred Name

Address: ______________ ______________
Address 1 Address 2

______________ ___ ______
City State Zip Code

Phone: ______ ______ ______ ____ **Best time to call:** ______________
Home Mobile Work Ext

Birth Date: SS#. College Name / Address (if applies)

____

____

Email Address:

____

____

Primary Insured's Employer Name Employer Phone#

____

____

Name of Insured: ______________ ______________ ___
Last First M

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: ______________________________

Insured's Birth Date SS#/ ID#. Phone#

____

____

Sec. Insured's Employer Name Employer phone #

____

____

Name of Insured: ______________ ______________ ___
Last First M

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: ______________________________

Insured's Birth Date SS#/ID# Phone# ○ Yes ○ No

Your Primary Physician's name, address, & phone number:

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Within the past year, have there been any changes in your general health? ○ Yes ○ No

☐ *Allergies	☐ AIDS	☐ Allergic to Bactrim	☐ Amoxicillan Allergy
☐ Anemia	☐ Arthritis	☐ Artificial Joints	☐ Asthma
☐ Blind	☐ Blood Disease	☐ Cancer	☐ Carbo
☐ Cerebal Palsy	☐ Chemotherapy	☐ Codeine Allergy	☐ Diabetes
☐ Dizziness	☐ Epilepsy	☐ Excessive Bleeding	☐ Fainting
☐ Glaucoma	☐ Growths	☐ Hay Fever	☐ Head Injuries
☐ Heart Attack	☐ Heart Disease	☐ Heart Murmur	☐ Heart Problem
☐ Hepatitis	☐ High Blood Pressure	☐ HIV	☐ Jaundice
☐ Keflex allergy	☐ Kidney Disease	☐ LATEX ALLERGY	☐ Liver Disease
☐ Mental Disorders	☐ Nervous Disorders	☐ NO-EPI	☐ Osteoporosis
☐ Pacemaker	☐ Penicillin Allergy	☐ Pregnancy	☐ PRE-MED
☐ Prosthetic Joints	☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever
☐ Rheumatism	☐ Sinus Problems	☐ Stomach Problems	☐ Stroke
☐ SULFA	☐ Tetracycline allergy	☐ Tuberculosis	☐ Tumors
☐ Ulcers	☐ Venereal Disease		

Are you allergic to any medications? Yes or No If Yes, please list.

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____

Are you an abnormal bleeder? ○ Yes ○ No

Do you have any other diseases than those listed? Yes or No If yes, please list.

____

____

List any drugs you are presently taking

____

____

In case of an emergency, please notify & emergency phone number

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Consent: The undersigned hereby authorized Doctor to take Xrays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorized Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with patient and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payments for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made.

Signature ______________________________ **Date** __________

I authorize my insurance company to pay the dentist or dental group all my benefits payable to me for services rendered. I authorize the use of this signature for all insurance submissions for all family members insured. I authorize the dentist to relased all information necessary to secure the payment of this benefit.

I understand that I am financially responsible for any charges incurred.

Signature ____ **Date** __________

Acknowledgement of Receipt of Notice of Privacy Practices and Communications Consent

I acknowledge that I have received or have been offered a copy of the Notice of Privacy Practices.

Signature ____ **Date** __________

I give my permission to be contacted in the following manner (check all that apply):

☐ Work Telephone

☐ Home Telephone

☐ Ok to leave message with information

☐ Leave message with call-back number only

☐ Written Communication (OK to mail to my home address)

☐ Patient information or medical records may be faxed to other care providers, hospitals or insurance companies if necessary.

Response Date: ____/____/________

Perrine & Staunton, DDS

IMPORTANT! PLEASE READ BEFORE SIGNING

Written Financial Policy

Thank you for choosing Perrine & Staunton, DDS dental office for your dental care. Our primary mission is to deliver the best quality and most comprehensive dental care available. An important part of the mission is making the cost of dental care as easy and manageable for our patients as possible by offering several payment options.

Forms of Payment

We accept Cash, Check, Visa, Mastercard, American Express, Discover Card, or Care Credit at time of service.

Payment Is Due At The Time Of Service

Appointments may be rescheduled until outstanding balances are cleared.

Discounts

We offer a 10% courtesy adjustment to patients who pay for their **entire treatment plans** with cash, or check only **prior to the start of treatment**. A 10% discount is offered to **senior citizens age 62 and above**. (No combined offers)

Insurance

As a **courtesy,** we offer to bill your insurance claims as a courtesy to you. **Estimated patient share and deductibles are due at the time of service.** Your insurance contract exists solely between you, your employer, and your insurance carrier. We will work with your insurance carrier to maximize your benefits to the best of our ability. * Although we file your insurance claims, we cannot guarantee any benefits. **Not all services are a covered benefit in all contracts.** Any questions regarding your benefits should be directed to your insurance carrier.

Financing

No Interest Payment Plans through **Care Credit** **

~ Allows you to pay over time with **No Interest**
~ No annual fees or prepayment penalties
~ Convenient low monthly payment plans

Major Treatment

On the day impressions are taken for: Crowns, bridges, partials, dentures, and lumineers, a payment of ½ of the patient share will be collected. The remaining patient share will be collected at the beginning of your completion visit.

I understand and accept the financial and dental insurance policies listed above and have had any and all questions answered to my satisfaction. I agree to pay for all treatment according to the above options. I authorize my insurance benefits to be paid directly to Drs. Perrine & Staunton. I realize I am responsible for any deductible amounts, my patient portion, and any non-covered services. I understand I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by said insurance and I agree to pay charges in full. I authorize release of pertinent medical/dental information to the insurance carrier(s). This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

X ____

PATIENT (or parent of minor) **DATE**

X ____

STAFF SIGNATURE **DATE**

*However, if we do not receive payment from your insurance carrier within 45 days, you will be responsible for the unpaid portion of treatment fees and a statement for this amount will be sent to you.

**If paid within promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required. Subject to credit approval.