

# DR. JULIA W. NEULS

WHO REFERRED YOU TO OUR OFFICE? \_\_\_\_\_

Date \_\_\_\_\_

Name \_\_\_\_\_ S.S. # \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ Apt.# \_\_\_\_\_

City/State \_\_\_\_\_ Zip Code \_\_\_\_\_ E-mail address \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Beeper # \_\_\_\_\_ Sex:  M  F Marital Status:  M  S  D  W

Driver's License # \_\_\_\_\_ State \_\_\_\_\_ Valid Thru \_\_\_\_\_

Spouse \_\_\_\_\_ Spouse's Place of Employment \_\_\_\_\_

Person responsible for account (if child, put parent's name) \_\_\_\_\_

Address (if different from above) \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_

## If Employed:

Name of Employer \_\_\_\_\_ Position \_\_\_\_\_

Address at Work \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone # \_\_\_\_\_

## DENTAL INSURANCE ONLY

#1 Insurance Company (Primary Carrier) \_\_\_\_\_ Ins. Co. Phone# \_\_\_\_\_

Name of Insured \_\_\_\_\_ DOB \_\_\_\_\_ S.S.# \_\_\_\_\_

#2 Insurance Company \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to Insurance Holder \_\_\_\_\_

## Nearest relative not in same household:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

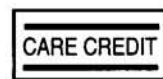
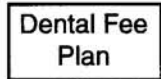
Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

How will you pay for services rendered on this initial visit?

Cash: \_\_\_\_\_ Check: \_\_\_\_\_ Credit Card # \_\_\_\_\_ Exp. Date \_\_\_\_\_



## FINANCIAL POLICY

It is the policy of this office, after examination and diagnosis, to make an estimate of the dentistry to be performed. This will enable you as the patient to know exactly what work is planned and what your financial responsibility will be.

It is necessary to make definite financial arrangements before any major dentistry is stated. There are several possible methods of payment.

**CURRENT ACCOUNT:** Payment in full at each appointment.

**RESTORATIVE ARRANGEMENT:** Fifty percent payment at preparation and the balance in full by date of cementation or delivery.

**PROSTHETIC ARRANGEMENT:** One-third at commencement of treatment, one-third at midway point, and the balance at completion or delivery.

**WE DO ACCEPT:** Visa, MasterCard, American Express, Discover and Care Credit.

(We offer the Dental Fee Plan - no money down and low monthly payments.)

A firm understanding of financial involvement is essential for mutual benefit before beginning treatment in order to maintain a favorable environment and to assist you, the patient, to plan accordingly.

**Out of respect for everyone's time we ask that you give us advanced notice of 2 working days when changing an appointment otherwise a nominal fee will be incurred.**

**MEDICAL HEALTH**

General Health (Please check) EXCELLENT  GOOD  FAIR  POOR

Name and phone number of physician \_\_\_\_\_

Name and address of previous dentist \_\_\_\_\_

Last complete physical? \_\_\_\_\_

Are you taking any medication now? Yes  No  For what purpose? \_\_\_\_\_

Names of medication \_\_\_\_\_

**HAVE YOU EVER BEEN TREATED FOR:**

- Heart disease..... Yes  No  Hepatitis..... Yes  No
- Rheumatic fever ..... Yes  No  Jaundice..... Yes  No
- Abnormal blood pressure..... Yes  No  Asthma or hay fever ..... Yes  No
- Ulcers ..... Yes  No  Sinus trouble ..... Yes  No
- Tuberculosis or lung disease..... Yes  No  Arthritis ..... Yes  No
- Diabetes ..... Yes  No  Stroke ..... Yes  No
- Epilepsy ..... Yes  No  Glaucoma..... Yes  No
- Anemia ..... Yes  No  Gonorrhea, Syphilis, Herpes..... Yes  No
- Congenital heart lesions ..... Yes  No  Tested HIV positive ..... Yes  No
- Allergies..... Yes  No  Any prosthetics i.e.: artificial hip, knee
- Heart murmur..... Yes  No  heart valve, etc..... Yes  No
- Mitral Valve..... Yes  No  Other illness? What \_\_\_\_\_

Do you need to pre-med for dental treatment? \_\_\_\_\_

Please check if you are allergic to: Penicillin  Codeine  Local injected anesthetics  Other medications

Do you take an aspirin every day? ..... Yes  No

Are you subject to prolonged bleeding? ..... Yes  No

Are you subject to fainting spells? ..... Yes  No

Do you have excessive urination and/or thirst? ..... Yes  No

(Women) Are you pregnant? ..... Yes  No  How long \_\_\_\_\_

**DENTAL HEALTH**

Have you ever had radiation treatment? ..... Yes  No

What is your immediate dental concern? \_\_\_\_\_

**DO YOU HAVE**

- Dental pain..... Yes  No
- Decayed teeth, broken or loose fillings
- loose teeth? ..... Yes  No
- Growths or swellings in your mouth?..... Yes  No
- Bleeding gums?..... Yes  No
- Sensitivity to temperature, pressure,
- food or drink?..... Yes  No
- An unpleasant taste or odor in your mouth..... Yes  No
- Dissatisfaction with your teeth
- and their appearance?..... Yes  No
- Dentures? ..... Yes  No

**HAVE YOU HAD**

- An unfavorable dental experience..... Yes  No
- Wisdom teeth removed? ..... Yes  No
- Other teeth lost?..... Yes  No
- A bad reaction to dental anesthetic?..... Yes  No
- Previous dental treatment you would like
- to discuss? ..... Yes  No
- Treatment by any dental specialist?..... Yes  No
- What? ..... Yes  No
- Facial or jaw pains? ..... Yes  No
- Gas for dental treatment? ..... Yes  No

I, the undersigned (patient) or legally responsible party), authorize dental treatment to be rendered by the dentist and his staff, and I assume all financial responsibility for treatment given, services rendered and all associated costs incurred as a result of my treatment. I have read, understand and agree that payment shall be made on time in accordance with the above terms and conditions. I agree to pay all costs of collection, court costs, attorney fees, billing cost, interest charges of 2% per month on the unpaid balance for accounts over 90 days and all other charges allowable under the law, incurred in the collection of amounts due. I acknowledge that all information contained herein is true and correct and give my permission to verify any of the information provided.

Date \_\_\_\_\_ Signature \_\_\_\_\_