WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

1) PERSONAL INFORMATION

Date: _____ Birthdate: _____

SS#: _____Email:_____

Name: _____ Nickname: _____

____Male ____Female __Minor __Single __Married __ Divorced__ Widowed__ Separated

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____Occupation:_____

Referred by: _____

2) RESPONSIBLE PARTY: Who is responsible for the account?

Name: _____ Relationship to patient: _____

Birthdate: _____ SS#:_____

Driver's License #:_____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Home: _____ Cell: _____Work:_____

3) TELEPHONE:

Home: _____ Cell: _____Work:_____

Where do you prefer to receive calls? ___Home ___ Cell ___ Work

When is the best time to reach you? Time_____ Days_____

In the event of an emergency, who should we contact?

Name: _____ Relationship: _____

Phone Number_____

4) DENTAL INSURANCE INFORMATION:

Primary

Name of insured: _____

Relationship to patient: _____

Insured's birthdate: _____

SS#_____

Employer: _____

Insurance Company: _____

Group #: _____

Member ID #: _____

Secondary

Name of insured: _____

Relationship to patient: _____

Insured's birthdate: _____

SS#_____

Employer: _____

Insurance Company: _____

Group #: _____

Member ID #: _____

5) AUTHORIZATION AND RELEASE:

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient or parent/guardian if minor DATE

6) FINANCIAL ARRANGEMENTS:

For your convenience, we offer the following methods of payment. Please check the option which you prefer. Payment in full is due at each appointment.

____ Cash ___Personal Check ___Credit Card _____ Care Credit ___I wish to discuss the dental office's policy

Late Charges: If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any further outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at any time, please ask – we are always happy to help.

Helton Family Dental Care, PA
Dr. John M. Helton and Dr. Joey V. Helton
662-257-9700

Financial Policy

We thank you for choosing Helton Family Dental Care! We are honored you have chosen us for your dental needs. Our primary mission is to provide the highest quality dental care for our patients in the most gentle, affordable, and efficient manner as possible.

For your convenience, we offer many different payment options. We accept the following forms of payment:

A. Cash or Check
B. All major credit cards
C. CareCredit-NO INTEREST payment plans available with convenient, low monthly payments. (Pending approval for those who do not already utilize CareCredit)
D. Dental Insurance-As a courtesy, we are happy to submit a pre-treat estimate and then file your insurance on treatment day to help maximize your benefits. However, when an estimate is given for payment by the insurance company, it IS NOT a guarantee of payment. You will be responsible for any amount not paid by your insurance company. Our front office staff will be happy to discuss financial arrangements before treatment is rendered.
E. We offer a 7% discount for patients without insurance who pay with cash or check when their charges are over $300, and they pay in full on their initial visit.
F. Payment is expected on the date of service.

A fee of no less than $50 will be charged for missed appointments that are not cancelled by giving at least 24 hours' notice.

A $40 returned check fee will be assessed on all returned checks.

"I understand that payment is due at the time of service. "I agree to pay collection fees of 33 1/3% of the unpaid balance at such time that my account is placed with a collection agency. I further agree that I am responsible for all costs associated with the collection of my account, including but not limited to postage costs, and all credit card processing costs. In the event my account is referred to an attorney for collection, I agree to be liable for attorney's fees of 33 1/3% of the unpaid balance, and all costs of court. I also authorize my employment location and status to be verified for the purpose of processing my bill for payment."

I authorize the use of the phone numbers and other contact information I provide, including my cellular number and any future number assigned to me, for calls, texts, emails, to include automated dialers, to contact me regarding my care and my account by this medical provider and this medical provider's business associates.

I have read and understand the Financial Policy at Helton Family Dental Care, PA. I understand payment is due at each visit unless arrangements have been made prior to my appointment.

Patient, Parent or Guardian Signature Date

Patient Name (Please Print) Date

MEDICAL HISTORY

PATIENT NAME _____ **BIRTH DATE** _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? O Yes O No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? O Yes O No If yes, please explain: _____
Have you ever had a serious head or neck injury? O Yes O No If yes, please explain: _____
Are you taking any medications, pills or drugs? O Yes O No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? O Yes O No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? O Yes O No _____
Are you on a special diet? O Yes O No _____
Do you use tobacco? O Yes O No _____
Do you use controlled substances? O Yes O No _____

Women: Are you
Pregnant/Trying to get pregnant? O Yes O No Taking oral contraceptives? O Yes O No Nursing? O Yes O No

Are you allergic to any of the following?
☐Aspirin ☐Penicillin ☐Codeine ☐Local Anesthesia ☐Acrylic ☐Metal ☐Latex ☐Sulfa drugs
☐Other If yes, please explain: _____

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

AIDS/HIV Positive	O Yes O No	Excessive Thirst	O Yes O No	Lung Disease	O Yes O No
Alzheimer's Disease	O Yes O No	Fainting Spells/Dizziness	O Yes O No	Mitral Valve Prolapse	O Yes O No
Anaphylaxis	O Yes O No	Frequent Cough	O Yes O No	Osteoporosis	O Yes O No
Anemia	O Yes O No	Frequent Diarrhea	O Yes O No	Pain in Jaw Joints	O Yes O No
Angina	O Yes O No	Frequent Headaches	O Yes O No	Parathyroid Disease	O Yes O No
Arthritis/Gout	O Yes O No	Genital Herpes	O Yes O No	Psychiatric Care	O Yes O No
Artificial Heart Valve	O Yes O No	Glaucoma	O Yes O No	Radiation Treatments	O Yes O No
Artificial Joint	O Yes O No	Hay Fever	O Yes O No	Recent Weight Loss	O Yes O No
Asthma	O Yes O No	Heart Attack/Failure	O Yes O No	Renal Dialysis	O Yes O No
Blood Disease	O Yes O No	Heart Murmur	O Yes O No	Rheumatic Fever	O Yes O No
Blood Transfusion	O Yes O No	Heart Pacemaker	O Yes O No	Rheumatism	O Yes O No
Breathing Problem	O Yes O No	Heart Trouble/Disease	O Yes O No	Scarlet Fever	O Yes O No
Bruise Easily	O Yes O No	Hemophilia	O Yes O No	Shingles	O Yes O No
Cancer	O Yes O No	Hepatitis A	O Yes O No	Sickle Cell Disease	O Yes O No
Chemotherapy	O Yes O No	Hepatitis B or C	O Yes O No	Sinus Trouble	O Yes O No
Chest Pains	O Yes O No	Herpes	O Yes O No	Spina Bifida	O Yes O No
Cold Sores/Fever Blisters	O Yes O No	High Blood Pressure	O Yes O No	Stomach/Intestinal Disease	O Yes O No
Congenital Heart Disorder	O Yes O No	High Cholesterol	O Yes O No	Stroke	O Yes O No
Convulsions	O Yes O No	Hives or Rash	O Yes O No	Swelling of Limbs	O Yes O No
Cortisone Medicine	O Yes O No	Hypoglycemia	O Yes O No	Thyroid Disease	O Yes O No
Diabetes	O Yes O No	Irregular Heartbeat	O Yes O No	Tonsillitis	O Yes O No
Drug Addiction	O Yes O No	Kidney Problems	O Yes O No	Tuberculosis	O Yes O No
Easily Winded	O Yes O No	Leukemia	O Yes O No	Tumors or Growths	O Yes O No
Emphysema	O Yes O No	Liver Disease	O Yes O No	Ulcers	O Yes O No
Epilepsy or Seizures	O Yes O No	Low Blood Pressure	O Yes O No	Venereal Disease	O Yes O No
Excessive Bleeding	O Yes O No			Yellow Jaundice	O Yes O No

Have you ever had any serious illness not listed above? _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ DATE _____