

Upland Smiles Dentistry

555 North Central Avenue, Upland, CA 91786 (909) 982-5960

FINANCIAL AGREEMENT

- * For my convenience, this office may release my information to my insurance company, and receive payment directly from them.
- * I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.
- * I agree to let this office run a credit report. Yes No. If no, then all fees are due at time of service.
- * If sent to collections, I agree to pay all related fees and court costs.
- * Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
- * **I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.**
- * **I will pay a fee of \$40 for APPOINTMENTS BROKEN without 24 hours notice and \$25 for returned checks.**
- * Treatment plans may change, and I will be responsible for the work actually done.

Signature _____ Date _____

NOTICE OF PRIVACY POLICIES

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities and health care operations. I also understand that I have the right to revoke permission.

Signature _____ Date _____

MEDICAL HISTORY

Name of Medical Doctor: _____ City/State _____

Emergency Contact _____ Phone _____ Relationship _____

List all the medications or drugs you are now taking: _____ List all the medications or drugs you are allergic to:
 None _____ None _____

List any medical conditions you may have including: AIDS/HIV, asthma, bleeding problems, cancer, diabetes, heart murmur, heart problem, hepatitis type: __, herpes, high blood pressure, joint replacement, kidney disease, liver disease, pregnancy, psychiatric treatment, sinus problem, stroke, ulcers, history of rheumatic fever or of taking fen-phen.

None _____

Tobacco use? If so, what kind and how much? _____

Unusual reaction to dental injections? _____

Reason for today's visit _____ Are you in pain? _____

New patients:

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? _____

Do you have Bite-Wing x-rays that are less than 1 year old? _____

Name of former dentist _____ City/State _____

Date of last cleaning and exam _____

Signature _____ Date _____

Dentist signature: _____ Date: _____