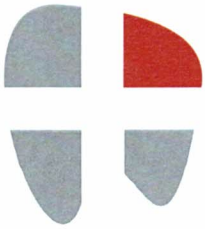

OnCall Dental®
URGENT CARE

Patient Information

LAST NAME | FIRST NAME | MIDDLE INITIAL | PREFERRED NAME

STREET | APT # | CITY | STATE | ZIP

EMAIL ADDRESS | DATE OF BIRTH | SOCIAL SECURITY NUMBER

WORK PHONE # | MOBILE PHONE # | HOME PHONE #

EMERGENCY CONTACT NAME | EMERGENCY CONTACT PHONE # | HOW DID YOU HEAR ABOUT US?

Financial Information

METHOD OF PAYMENT: O SELF-PAY O INSURANCE

RESPONSIBLE PARTY INFORMATION

FULL NAME | DATE OF BIRTH | SOCIAL SECURITY NUMBER

PRIMARY INSURANCE COMPANY | EMPLOYER

POLICY HOLDER (SUBSCRIBER) | DATE OF BIRTH | ID#/SSN

Dental Information

WHAT IS THE REASON FOR TODAY'S VISIT?

HOW LONG SINCE YOUR LAST DENTAL VISIT? | LAST CLEANING? | LAST X-RAYS?

WHAT WOULD YOU LIKE TO ACCOMPLISH DURING TODAY'S VISIT?

- THE FOLLOWING CONFIDENTIAL INFORMATION IS FOR OUR RECORDS ONLY -

Medical History and Information

- CURRENTLY UNDER MEDICAL CARE | O YES | O NO

_____

IF YES, PLEASE EXPLAIN

- CURRENTLY TAKING ANY MEDICATIONS | O YES | O NO

_____

IF YES, LIST MEDICATIONS | VITAMINS | SUPPLEMENTS

_____

- DO YOU TAKE ANY BLOOD THINNERS | O YES | O NO

_____

IF YES, THEN WHY?

- HAVE YOU EVER TAKEN BISPHOSPHONATE MEDICATIONS? | O YES | O NO

_____

IF YES, THEN WHY?

INDICATE ANY ALLERGIES YOU HAVE TO THE FOLLOWING:

O ASPIRIN O CODEINE O PENICILLIN O LATEX O LOCAL ANESTHETIC

O OTHER: _____

INDICATE ANY OF THE FOLLOWING WHICH YOU HAVE HAD:

O ASTHMA O EPILEPSY O DIABETES O HIV/AIDS O INFECTIOUS DISEASE

O HEPATITIS O STROKE O HEART PROBLEMS/*SURGERY O IMMUNE DISORDER O HIGH BLOOD PRESSURE

O OTHER _____

FEMALE PATIENTS: _____ | _____

ARE YOU PREGNANT? IF YES, DUE DATE

Treatment Authorization

BEFORE TREATMENT IS RENDERED, ADEQUATE RADIOGRAPHS OF THE TEETH AND MOUTH MUST BE TAKEN. I AUTHORIZE AND GIVE CONSENT TO PERFORM DENTAL SERVICES AGREED BETWEEN THE DOCTOR AND PATIENT AND/OR PARENT OR GUARDIAN TO BE NECESSARY OR ADVISABLE INCLUDING THE USE OF LOCAL ANESTHESIA AND OTHER MEDICATION AS INDICATED. I CERTIFY TO THE ABOVE STATEMENTS REGARDING MY MEDICAL CONDITION.

PAYMENT FOR ALL TREATMENT AND SERVICES RENDERED ARE MY RESPONSIBILITY.

X _____ _____

PATIENT/LEGAL GUARDIAN SIGNATURE DATE

OnCall Dental
URGENT CARE

Payment Agreement

We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

Payment is due at the time service is provided. Our office accepts cash, MasterCard, Visa, American Express, Discover (outside financing upon approval).

For our patients with Dental Benefits; as a courtesy to you we will help you process all your insurance claims.

All charges you incur are your responsibility regardless of your insurance coverage.

If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

I AUTHORIZE ONCALL DENTAL URGENT CARE TO BILL MY INSURANCE COMPANY AS WELL AS ALLOW MY DENTAL BENEFITS TO BE PAID DIRECTLY TO ONCALL DENTAL URGENT CARE.

X _____ _____

PATIENT SIGNATURE (PARENT/GUARDIAN OF MINOR) DATE

HIPAA/Privacy Rule

A major goal of the HIPAA/Privacy Rule is to assure that individuals' health information is properly protected while still providing the highest quality of dental care. OnCall Dental Urgent Care will not release any information without the authorization of the patient. Under the HIPAA laws OnCall Dental Urgent Care is authorized to share needed information to the patient themselves, guardians, insurance companies, primary care physicians as well as law enforcement agencies.

I give the following people (listed below) access to my dental records.

Please check the following for communication preferences

I ☐ give / ☐ don't give Permission to Text
I ☐ give / ☐ don't give Permission to Leave a Voice Message

Your signature on this form certifies that you have read and understand the privacy laws.

X _____ _____

PATIENT SIGNATURE (PARENT/GUARDIAN OF MINOR) DATE

OnCall Dental®
URGENT CARE

Treatment Consent

I do hereby acknowledge, agree, and give my voluntary consent for treatment provided through OnCall Dental Urgent Care as may be deemed necessary or desirable by my treating professional(s), their assistants, and/or designees. This authorization includes, but is not limited to, routine diagnostic procedures, outpatient care, laboratory tests, and x-rays. I understand that my treatment may include a variety of interventions. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me as to results of examination and treatment received at the office. I acknowledge that my care is under the direction of my treating professional(s) and I represent that I will follow the instructions of my professional(s) in the provision of said care. Before receiving treatment you should ask the dentist about the procedure(s) that he/she recommends you undergo, and ask any questions you may have before you decide whether or not to give your consent for the procedure(s) to be done. All dental procedures may involve risks of unsuccessful results and complications, and no guarantee is made as to result of cure. You have the right at all times to be informed of any such risks as well as the nature of the procedure, the expected benefit, the availability of alternative methods of treatment, and the risks of no treatment. You have the right to consent to or refuse any proposed procedure at any time prior to its performance.

Your signature on this form certifies that you have read and understand the information provided on the form, that you have received a copy, and that you accept dental care and treatment under the described terms and conditions.

X _____ _____

PATIENT SIGNATURE (PARENT/GUARDIAN OF MINOR) DATE