COKER DENTAL

William "Tad" Coker III, D.D.S.

PATIENT INFORMATION

LAST NAME FIRST NAME MIDDLE INITIAL SOCIAL SECURITY # BIRTH DATE

ADDRESS

HOME TELEPHONE (WITH AREA CODE) CELL PHONE (WITH AREA CODE) ***E-MAIL**

PLEASE MARK APPROPRIATE STATUS: ☐MINOR ☐SINGLE ☐MARRIED ☐OTHER: _____

IF STUDENT, NAME OF SCHOOL/COLLEGE CITY/STATE _____FULL TIME ___PART TIME STATUS

EMPLOYER WORK TELEPHONE (WITH AREA CODE)

PARENT OR GUARDIAN (IF MINOR)

CONTACT (IN CASE OF EMERGENCY) RELATIONSHIP

ADDRESS TELEPHONE NUMBER (WITH AREA CODE)

WHO MAY WE THANK FOR REFERRING YOU TO US?

GUARANTOR/RESPONSIBLE PARTY

PERSON RESPONSIBLE FOR ACCOUNT SOCIAL SECURITY # BIRTH DATE

ADDRESS

EMPLOYER WORK TELEPHONE (WITH AREA CODE)

PLEASE NOTE: A PARENT OR LEGAL GUARDIAN MUST ACCOMPANY PATIENTS UNDER 18 YEARS OF AGE FOR ALL SERVICES EXCEPT FOR ROUTINE RECALL CLEANINGS.

PAYMENT

PAYMENT FOR SERVICES FOR THE TREATMENT OF MINORS IS THE RESPONSIBILITY OF THE ADULT ACCOMPANYING THAT MINOR.

PAYMENT IN FULL OF SERVICES PLANNED FOR THAT TREATMENT DAY IS EXPECTED AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE WITH OUR FINANCIAL COORDINATOR. PLEASE ASK ABOUT OUR SEVERAL PAYMENT OPTIONS. WE ACCEPT CASH, PERSONAL CHECKS, VISA, MASTERCARD, DISCOVER AND CARE CREDIT

.

MISSED APPOINTMENTS

ONCE AN APPOINTMENT HAS BEEN MADE, PLEASE REMEMBER THAT THIS TIME HAS BEEN SPECIFICALLY RESERVED FOR YOU. WE WILL MAKE EVERY EFFORT TO REMIND YOU OF YOUR APPOINTMENT BUT, ULTIMATELY, YOUR APPOINTMENTS ARE YOUR RESPONSIBILITY. WE RESERVE THE RIGHT TO CHARGE A FEE FOR ANY APPOINTMENTS MISSED OR CANCELLED WITHIN A 24-HOUR PERIOD OF THE APPOINTMENT.

INSURANCE INFORMATION

OUR OFFICE IS COMMITTED TO HELPING OUR PATIENTS MAXIMIZE THEIR INSURANCE BENEFITS. AS YOU MAY BE AWARE, DENTAL INSURANCE IS EXTREMELY COMPLEX. WE ARE ALWAYS AVAILABLE TO ANSWER YOUR QUESTIONS, HOWEVER, **your insurance policy is an agreement between you and your employer/insurance carrier and as a dental provider, we are not party to that agreement. Your patient portion must be paid before or at the time of service. We ask our patients to provide us with their complete dental insurance information. *If the information provided is incorrect, you will be responsible for payment in full immediately.*** AS A SERVICE TO OUR PATIENT, WE WILL PROCESS ALL PRIMARY AND SECONDARY INSURANCE CLAIMS FOR SERVICES AND ALLOW THEM 45 DAYS TO RENDER PAYMENT IN FULL. AFTER 60 DAYS, THE PATIENT IS RESPONSIBLE FOR THE ENTIRE BALANCE AND IT WILL BE DUE IN FULL. THE QUALITIES OF INSURANCE POLICIES VARY GREATLY; THEREFORE WE CAN ***estimate*** YOUR COVERAGE IN GOOD FAITH, BUT CANNOT GUARANTEE COVERAGE DUE TO THE COMPLEXITIES OF INSURANCE CONTRACTS.

NAME OF DENTAL INSURANCE: _____ GROUP NUMBER: _____

SUBSCRIBER NAME: _____ SUBSCRIBER SSN/ID #: _____

SECONDARY INSURANCE: _____ GROUP NUMBER: _____

SUBSCRIBER NAME: _____ SUBSCRIBER SSN /ID #: _____

CURRENT HEALTH HISTORY

PRIMARY CARE PHYSICIANS NAME: _____OFFICE PHONE NUMBER: _____

LAST MEDICAL EXAM: _____ LAST DENTAL EXAM: _____

HAVE YOU BEEN UNDER A DOCTOR'S CARE WITHIN THE LAST 5 YEARS? ☐YES ☐ NO

If yes, please explain: _____

WOMEN: ARE YOU PREGNANT? ☐YES ☐NO if yes, date you are due: _____

	YES	NO		YES	NO
ALLERGY TO PENICILLIN	☐	☐	HEPATITIS OR LIVER PROBLEMS		
			Type: _____	☐	☐
ALLERGY TO OTHER DRUGS	☐	☐	HIGH BLOOD PRESSURE	☐	☐
If yes, please list: _____					
_____			KIDNEY INFECTION OR PROBLEMS	☐	☐
ALLERGY TO ANESTHETICS, NOVOCAIN	☐	☐	LATEX ALLERGY	☐	☐
OR XYLOCAINE	☐	☐	MITRAL VALVE PROLAPSE	☐	☐
ANEMIA OR BLOOD PROBLEMS	☐	☐	PACEMAKER	☐	☐
ARTHRITIS OR GOUT	☐	☐	PROSTHETIC JOINTS OR REPLACEMENTS	☐	☐
ASTHMA OR OTHER RESPIRATORY PROBLEMS	☐	☐	PSYCHIATRIC CARE/EMOTIONAL PROBLEMS	☐	☐
HAVE YOU EVER HAD A BLOOD					
	☐	☐	RADIATION TREATMENT/CHEMOTHERAPY	☐	☐
HAVE YOU EVER HAD A BLOOD					
TRANSFUSION	☐	☐	RHEUMATIC FEVER		
CANCER, LEUKEMIA, OR MALIGNANCIES	☐	☐	SCARLET FEVER	☐	☐
DIABETES	☐	☐	DO YOU SMOKE?	☐	☐
DIZZINESS/FAINTING SPELLS/EPILEPSY	☐	☐	STOMACH PROBLEMS/ULCERS	☐	☐
EXCESSIVE BLEEDING	☐	☐	STROKE	☐	☐
ARE YOU AT RISK FOR ANY IMMUNE RELATED					
DISEASES --- HIV/AIDS	☐	☐	THYROID PROBLEMS	☐	☐
HAY FEVER OR ALLERGIES IN GENERAL	☐	☐	TUBERCULOSIS	☐	☐
HEART AILMENTS OR PROBLEMS	☐	☐	YELLOW JAUNDICE	☐	☐

HEART ATTACK ☐ ☐ OTHER: _____

LIST ANY MEDICATIONS YOU ARE PRESENTLY TAKING: _____

_____

_____

_____

UNLESS A MEDICAL DOCTOR CLEARS YOU; PREMEDICATION IS REQUIRED FOR TREATMENT OF PATIENTS WITH, OR PREVIOUSLY HAD, RHEUMATIC FEVER, MITRAL VALVE PROLAPSE, OR JOINT REPLACEMENT.

IF HEALTHCARE WORKERS ACCIDENTALLY EXPOSE THEMSELVES TO MY BLOOD OR BODY FLUIDS IN THE COURSE OF PROVIDING HEALTH CARE FOR ME, I AGREE TO HAVE MY BLOOD TESTED FOR ANY INFECTIOUS DISEASE, WHICH MIGHT BE TRANSMITTED TO THEM THROUGH THIS EXPOSURE, INCLUDING HIV/AIDS AND HEPATITIS.

SERVICE CHARGES

WE WILL CHARGE A 1.5% MONTHLY (18% ANNUAL PERCENTAGE RATE) OR BILLING CHARGE WHICH WILL BE APPLIED TO ALL ACCOUNTS OVER 60 DAYS PAST DUE. WE WILL CHARGE $30.00 FOR ALL RETURNED CHECKS. ANY FEES INCURRED TO COLLECT PAYMENT FROM A PROFESSIONAL AGENCY WILL BE BILLED TO AND PAYABLE BY THE PATIENT OR THE PATIENT'S RESPONSIBLE PARTY.

FINANCIAL CONSENT

THE PATIENT OR RESPONSIBLE PARTY AGREES TO BE FULLY RESPONSIBLE FOR THE TOTAL TREATMENT PERFORMED IN THIS OFFICE.

I UNDERSTAND AND AGREE TO THIS OFFICE AND FINANCIAL POLICY AND AGREEMENT.

THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

_____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY DATE

*** WILLIAM L COKER III DDS WILL NOT SELL, EXCHANGE, OR OTHERWISE GIVE AWAY YOUR EMAIL ADDRESS TO ANYONE FOR ANY REASON. WHEN YOU PROVIDE YOUR EMAIL ADDRESS, IT IS USED FOR OUR INTERNAL MARKETING AND CONTACT PURPOSES ONLY. AGAIN, IT IS OUR POLICY TO HOLD YOUR EMAIL ADDRESS IN THE STRICTEST OF CONFIDENCE.**