

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____

Male Female

Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street

Apartment #

City

State

Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street

City

State

Zip Code

Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Last

First

MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street

City

State

Zip Code

Insured's Employer Name: _____

Address: _____

Street

City

State

Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Last

First

MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street

City

State

Zip Code

Insured's Employer Name: _____

Address: _____

Street

City

State

Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services, deductibles co-payments and/or amounts not covered by the insurance carrier. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. It is the patients' responsibility to know his/her insurance benefits.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. If the account is referred to an attorney for collection, the patient or responsible party will pay any attorney's fee of 33.33% of this balance and all court costs incurred. Should any of my checks be returned for nonpayment, then I agree to pay a bank charge of \$25.00 per check. I agree that the courts of Rhode Island shall be the exclusive forum. I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by Dr. Karkalas, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

The undersigned hereby authorizes Dr. Lena Karkalas to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Karkalas to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Karkalas to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian (guarantor of payment/responsible party) _____ Date: _____

Relationship to patient _____

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Dental History

Your current dental health is? Good Fair Poor

Why have you come to the Dentist today? Are you currently in any pain or discomfort? _____

Have your past dental experiences been comfortable? Yes No

What Part(s) of Dental treatment make you most anxious? _____

Are there spaces between your teeth? Yes No

Are any of your teeth loose? Yes No

Do your gums ever bleed? Yes No

Are there any sores or growths in your mouth? Yes No

Do you think you have bad breath? Yes No

Do you think you grind or clench your teeth? Yes No

Do you have Pain or Clicking in the Jaw Joint around your ear? Yes No

Do you like your smile? Yes No Please explain _____

Would you like to whiten your teeth? Yes No

Have you ever whitened your teeth? Yes No

Do you drink Coffee or Tea? Yes No

What type of toothbrush do you use? Hard Medium Soft

How many times a day do you brush? _____ Floss _____

What major concerns do you have with your mouth and teeth? _____

Name/City of previous Dentist _____

When was your last: **Full set of x-rays** _____

Dental Cleaning _____

**Dr. Lena D. Karkalas DDS. LTD
151 Waterman Street
Providence, RI. 02886**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received a copy of the **NOTICE OF PRIVACY PRACTICES**,
And understand my rights for confidentiality and as the law pertains.

Name (Please Print)

Signature

Date

**Please Note: It is your right to refuse to sign this acknowledgement.
You may also request a copy of the office Privacy Act at any time.**

Office Use Only

We tried to obtain written acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

- An emergency prevented us from obtaining acknowledgement.
- A communication barrier prevented us from obtaining acknowledgement.
- The individual was unwilling to sign.
- Other:

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