Keenan W. Green, D.M.D.

PATIENT ACQUAINTANCE FORM

Name _____ Address _____
City _____ State _____ Zip _____ Home Phone _____
Work Phone _____ Sex (M/F) _____ Marital Status _____
Birthdate _____ Social Security # _____
Name of Responsible Party _____ Referred by _____

HEALTH HISTORY

Any Allergies? _____
Medications Presently Taking (including aspirin, etc.): _____

Have you ever had or have you now: (Please check at the right of each item)

(check each item)	YES	NO	DON'T KNOW	(check each item)	YES	NO	DON'T KNOW
Epilepsy or Seizures				Tuberculosis/PPD positive			
Fainting or Dizziness				Asthma			
Nervousness				Hay Fever			
Stroke				Sinus Problems			
Glaucoma				Anemia			
Cold Sores (Herpes)				Sickle Cell Disease			
Persistent Cough				Hemophillia			
Emphysema				Bruise or bleed easily			
Heart Problems				Prosthetic heart valve			
Angina				Pacemacker			
Hypertension				Blood Transfusion (s)			
Rheumatic Fever				Liver Disease			
Heart Murmur				Yellow Jaundice			
Mitral Valve Prolapse				Hepatitis -Type			
Congenital heart lesions				Ulcers			
Heart surgery				Kidney Problems			

Patient, Parent or Guardian Signature _____

INSURANCE INFORMATION

Name of Insured _____ Birthdate _____ SSN#_____
Employer Name _____ Address _____
City _____ State _____ Zip _____ Work # _____

Insurance Company Name _____

I authorize release of any information needed for filing dental claims and authorize payment directly to the dentist.

Signature _____ Date _____

Returned checks will have a $15.00 returned check charge added and balances older than 60 days may be subject to interest charges of 1.5% per month.

FINANCIAL POLICY

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship.

FULL PAYMENT IS DUE AT TIME OF SERVICE for any amount that will not be paid by insurance.

EMERGENCY PATIENTS: If you are not a patient on record and require emergency treatment you must pay in full at time of treatment. Our office will then provide you with the necessary paperwork to allow you to file for reimbursement from your insurance company.

INSURANCE: We will file claims to most insurance companies for you. We will need a copy of your insurance card and driver's license.

DISCOUNTS: A 10% discount will be given for cash payment WHEN PAID IN FULL at time of service.

USUAL AND CUSTOMARY: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MEDICAL INFORMATION RELEASE: I give permission for the release of any medical or dental information needed by my insurance company.

LATE CHARGES: Late charges may apply to any past due balance. If it is necessary to take collection action against a past due account, any collection fees incurred will be the responsibility of the patient and will be charged to their account. Any rebilling of an account will result in a $3.00 rebilling fee.

MISSED APPOINTMENTS: Any missed appointments without 24 hour notice may require an office visit to be charged to the patients account.

If dental insurance assignment is accepted, I authorize payment directly to Dr. Keenan Green for any insurance benefits otherwise payable to me.

SIGNATURE OF RESPONSIBLE PARTY OR PATIENT: _____