Peculiar Dental Care

EXCEPTIONAL DENTISTRY ♡ EXTRAORDINARY CARE

Welcome to our office! We are so glad that you have chosen us as your dental home. We value each and every patient that we have an opportunity to serve. Our goal is to make this one of the best dental experiences that you have ever had. We care about YOU and will make time to listen. We are a small office with small-town values and we focus on providing *exceptional* dentistry and building relationships with our patients that will last a lifetime. We want you to feel comfortable and at ease, knowing that you have kind, excellent, and compassionate professionals who will always complete your dental care with *integrity.*

So that we may best serve you, please complete these forms before your appointment. If you should have any questions or concerns, please do not hesitate to ask for assistance. Thank you. We look forward to meeting you soon!

General Patient Information

1. Name: _____
First **MI** **Last** **Preferred**

2. Address: _____
Street **City** **State** **Zip**

3. Date of Birth: _____ _____ _____
Month **Day** **Year**

4. Social Security #: _____

5. Employer: _____

6. Contact Information:

May we:

a. Cell Phone #: _____ Text You: Yes No

b. Home Phone #: _____

c. Work Phone #: _____

d. E-mail: _____ E-mail You: Yes No

****If under 18:** **Responsible Party Name**:_____ **Phone Number**:_____

How Did You Hear About Us?_____

(If someone referred you to our office, please write down their name so we can thank them.)

Have you been seen by another dentist or specialist in the last year? Yes No

What treatments(s) were performed?_____ **Date:**_____

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Emergency Contact:

Name:_____ **Relationship**_____
First **Last**

Phone (Hm): _____ **(Cell):** _____

If You Have Dental Insurance, Please Complete the Information Below:

Primary Insurance:

Insurance Company: _____

Policy Holder's Name:_____

Policy Holder's Birth Date:_____

Policy Holder's ID or SS#:_____

Relationship to Policy Holder:_____

Secondary Insurance:

Insurance Company: _____

Policy Holder's Name:_____

Policy Holder's Birth Date:_____

Policy Holder's ID or SS#:_____

Relationship to Policy Holder:_____

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Medical History Information

Please Answer Yes or No for All of the Following:

CONDITIONS:

Y	N	
☐	☐	Abnormal Bleeding
☐	☐	Alcohol and/or Drug Abuse
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Bleeding Disorder
☐	☐	Cancer (Date _____) Type: _____
☐	☐	Chemotherapy
☐	☐	Chewing Tobacco Use # of Years _____
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Diabetes 1 or 2 (Circle)
☐	☐	Difficulty Breathing
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Facial Surgery
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches
☐	☐	Glaucoma
☐	☐	HIV or AIDS
☐	☐	Heart Attack (Date_____)

Y	N	
☐	☐	Heart Murmur
☐	☐	Heart Surgery (Date_____)
☐	☐	Hemophilia
☐	☐	Hepatitis A B C (Circle)
☐	☐	High Blood Pressure
☐	☐	Joint Replacement
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Psychiatric illness Diagnosis _____
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	STD
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems
☐	☐	Smoker # of Years _____ Packs Per Day _____
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers

ALLERGIES:

Y	N	
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Sulfa
☐	☐	Tetracycline
☐	☐	Clindamycin
☐	☐	Other:_____

OTHER CONDITIONS:

_____

_____

Do You Have a Physician?

Y☐ N☐

Physician's Name: _____

City: _____

Phone: _____

Date of Last Visit: _____

FEMALES:

Are you...

☐ ☐ Pregnant - Weeks____

☐ ☐ Nursing

☐ ☐ On Birth Control

Please List All Medications You Are Taking:

_____

_____

☐ **No Medications**

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his staff, responsible for any errors or omissions that I have made in the completion of this form. If I ever have any change in my health, I will inform the Doctor at my next appointment.

_____ _____ _____

(PRINT) Patient Name (SIGN) Patient or Guardian of Minor (Date)

OFFICE USE ONLY: _____ _____

Signature of Doctor Date

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Financial Policies

Financial Policy Agreement

The patient and/or responsible party listed below hereby agree to pay all charges submitted by the office during the course of treatment for the patient. If the patient has dental insurance coverage, the patient and/or responsible party agree to pay all applicable co-payments and deductibles associated with treatment. The patient/responsible party also agree/agrees to pay for treatment rendered, which is not considered to be a covered service by a third party insurance or payers.

Full payment of fees and/or insurance co-payments or deductibles are **due on the day services are rendered** unless prior financial arrangements have been made with Dr. Buse. Payments can be made by cash, check or various charge cards accepted by Daniell J. Buse, D.D.S., LLC.

My method of payment will be: Cash:___ *Check:___ *Credit Card___

** Please Note: A service charge for insufficient funds will be assessed. Currently this fee is $35 and may change without notice.*

If payment for services rendered is not collected from You in a timely manner, You will be responsible, up to limitations set by law, for fees charged by collection agencies or attorneys in situations where they are involved in the collection of account balances. If Your account is sent to collections, this may result in You being unable to receive additional services except for emergency treatment, or you may be requested to pre-pay for future services.

NOTE**:** It is especially important that you keep your scheduled appointment times. We reserve this time for you and cannot fill this time slot without proper notice. This office exercises the right to charge for failed appointments and appointments that are not cancelled within 24 business hours. The fee is currently $75/hr for Dr Treatment, $45/hr for Hygiene Treatment.

Dental Insurance

We will submit Your dental insurance claims as a courtesy to You. You are expected to pay any estimated co-payments or deductibles on the day services are rendered. If insurance reimbursement is not received at our office or your claim is denied, or your insurance company covers less of a procedure than estimated, you will be billed the remaining balance due.

Assignment and Release of Insurance Benefits

I, the undersigned, have insurance with _____
(Name of Insurance Companies)

And assign directly to Dr. Daniell J. Buse all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Privacy Practices

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

I understand that this signature applies to all above stated policies.

_____ _____ _____

Patient's Name Signature of Patient Date