Implant & Cosmetic Dentistry

1329 Main Street • Rochester, IN 46975-2107 (574)223-3121

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart#: ____________________
FOR OFFICE USE ONLY

Patient Name: ____________________ Last ____________________ First ____ MI ____________________ Preferred Name

Title: ____________ Mr/Ms/Mrs/etc **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ______________ **SS#:** ___-__-____ **Prev. Visit:** ______________

Email Address: ______________________________ **Best time to call:** ____________________

Phone: __________ Home __________ Mobile __________ Work ______ Ext __________ Fax __________ Other

Address: ______________________________ Address 1 ______________________________ Address 2

______________________________ City ______ State _____-____ Zip Code

Drivers License Number, issuing state, expiration date:

____

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Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Yellow Pages ☐ Internet ☐ Newspaper ☐ Radio ☐ Work

☐ Other (name below):

Name of person, office, or other source referring you to our practice:

____

Emergency Contact: (NOT in same household)

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Reason for todays dental visit:

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Spouse or Responsible Party Information

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: ______________ ______________ ____ ______________
Last First MI Preferred Name

Title: __________ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: ____________ **Email Address:** ______________________________

Phone: __________ __________ __________ ______ **Best time to call:** ______________
Home Mobile Work Ext

Address: ______________________________ ______________________________
Address 1 Address 2

______________________________ ______ _____-____
City State Zip Code

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: ______________________________ **Phone:** ______________

Employer Address: ______________________________ ______________________________
Address 1 Address 2

______________________________ ______ _____-____
City State Zip Code

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: ______________________ ______________________ ____
Last First MI

Insured's Birth Date: __________ **ID #:** ______________ **Group #:** __________

Insured's Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ ______-____
City State Zip Code

Insured's Employer Name: ______________________________________

Employer Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ ______-____
City State Zip Code

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

Insurance Plan Name: ______________________________________

Insurance Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ ______-____
City State Zip Code

CONSENT FOR SERVICES

I give my consent to be a patient at the above named office and agree to the recommended dental treatment deemed necessary by Dr. H. Ray Hazen. I also understand and consent to the following:

During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, and radiography.

I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and give consent to my dentist to communicate with my other medical practitioners to inquire about any aspect of my health history.

No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

FINANCIAL CONSENT

We prepare treatment plan estimates so that patients are aware of their estimated cost of treatment prior to start. This Estimate is a good-faith attempt to predict the cost of your treatment based on the known facts when an estimate is made. As your treatment progresses, your dentist may determine that a change or an additional treatment may be necessary and that would change the estimated cost.

I agree to pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been preapproved, I am responsible for any costs that my Insurance does not cover.

I hereby authorize my insurance benefits to be paid directly to Dr. H. Ray Hazen. I realize that I am responsible for paying any deductible amount(s), my co-insurance portion and for any non-covered services. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by said insurance and I agree to pay such charges in full. I also hereby authorize the release of any and all pertinent medical/dental information to the insurance carrier(s).

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

Response Date: ___________