Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill our this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Patient Information (CONFIDENTIAL)

Name _____ Date of Birth _____ Social Security Number _____

Address _____ City _____ State ___ Zip _____

Home Phone Number _____ Work Phone Number _____ Cell Phone Number _____

Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Seperated ☐

If Student, Name Of School /College _____ City _____

Patient's Or Parent's Employer _____

Business Address _____ City _____ State _____

Spouse Or Parent's Name _____ Referred By _____

Person To Contact In Case Of Emergency _____

Responsible Party

Name Of Person Responsible For This Account _____

Relationship to Patient _____ Address _____

Home Phone Number _____ SS# _____ DOB _____

Employer _____ Work Telephone Number _____

Is This Person Currently A Patient At Our Office _____

Insurance Information

Name Of Insured _____ Relationship To Patient _____

DOB _____ SS# _____ Date Employed _____

Name Of Employer _____ Work Telephone Number _____

Address Of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID# _____

Insurance Company Address _____ City _____ State _____ Zip _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES ☐ NO ☐

Name Of Insured _____ To Patient _____

DOB _____ SS# _____ Date Employed _____

Name Of Employer _____ Work Telephone Number _____

Address Of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID# _____

Insurance Company Address _____ City _____ State _____ Zip _____

(OVER PLEASE)

Patient Medical History

Patient Name _____ Date _____ Physican _____ DOB _____

Are you under medical treatment now? ..... Yes No
Have you ever been hospitalized for any
surgical operations or serious illness? ..... Yes No
If yes what _____

_____

Are you taking any medications including
non-prescription medicine? ..... Yes No
If yes what _____

_____

Do you use tobacco? ..... Yes No
Do you use alcohol? ..... Yes No
Do you use cocaine or other drugs? ..... Yes No
Are you wearing contact lenses? ..... Yes No

Are you allergic to or have you had any reactions to the
Following:
Local anesthetics (eg. Novocaine) ..... Yes No
Penicillin or other Antibiotics ..... Yes No
Sulfa Drugs ..... Yes No
Barbiturates ..... Yes No
Sedatives ..... Yes No
Iodine ..... Yes No
Aspirin ..... Yes No
Latex ..... Yes No
Other _____

Women Only:
Are you pregnant or think you may be? ..... Yes No
Are you nursing? ..... Yes No
Are you taking birth control pills? ..... Yes No

Do you have or have you had any of the following? (PLEASE CIRCLE ALL THAT APPLY)

High Blood Pressure
Heart Attack
Rheumatic Fever
Swollen Ankles
Fainting/Seizures
Asthma
Low Blood Pressure
Epilepsy/Convulsions
Leukemia
Diabetes
Kidney Diseases
Other _____

Heart Disease
Cardiac Pacemaker
Heart Murmur
Angina
Frequently Tired
Anemia
Emphysema
Cancer
Arthritis
Joint Replacement or Implant
Hepatitis/Jaundice
Thyroid Problem

Chest Pains
Easily Winded
Stroke
Hay Fever/Allergies
Tuberculosis
Radiation Therapy
Glaucoma
Recent Weight Loss
Liver Disease
Respiratory Problems
Stomach Troubles/Ulcers
Mitral Valve Prolapse

Patient Dental History

Do your gums bleed while brushing or flossing? ..... Yes No
Are your teeth sensitive to hot or cold liquids/foods? ..... Yes No
Are your teeth sensitive to sweet or sour liquids/foods? ..... Yes No
Do you feel pain to any of your teeth? ..... Yes No
Do you have any sores or lumps in or near your mouth? Yes No
Have you had any head, neck or jaw injuries? ..... Yes No
Have you ever experienced any of the following problems
in your jaw?
Clicking? ..... Yes No
Pain (joint, ear, side of face) ..... Yes No
Difficulty in opening or closing? ..... Yes No
Difficulty in chewing? ..... Yes No

Do you have frequent headaches? ..... Yes No
Do you clench or grind your teeth? ..... Yes No
Do you bite your lips or cheeks frequently? ..... Yes No
Have you ever had any difficult extractions in
the past? ..... Yes No
Have you had orthodontic work? ..... Yes No
Have you ever had any prolonged bleeding
following extractions? ..... Yes No
Have you ever had instruction on the correct
method of brushing your teeth? ..... Yes No
Have you ever had instructions on the care
of your gums? ..... Yes No

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payble to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services tendered on my behalf or my dependents.

X _____

FOR YOUR CONVENIENCE THE FOLLOWING PROGRAMS ARE AVAILABLE TO HELP PLAN YOUR DENTAL INVESTMENT:

☐ **Plan 1 Payment in full at the time of service. ALL emergency appointments are payment at the time of service.**

☐ **Plan 2 Submit to dental insurance. Patient will immediately be responsible for the balance NOT paid by insurance. (CO-PAYMENTS DUE AT TIME OF SERVICE!)**

☐ **Plan 3 Equality Care. Please note-for ALL EQUALITY CARE PATIENTS, if there is a procedure code that Equality Care does NOT pay on, the patient is responsible for the charge in full. NO EXCEPTIONS!**

☐ **Other** _____

The fee for services provided is a charge based upon what your dentist determines during the preliminary oral exam and x-rays. Because, even with x-rays, it is not always possible to diagnose every fault in teeth, it may later be determined that additional dental work is necessary. In such a case, you will be notified.

FEDERAL TRUTH IN LENDING STATEMENT FOR SERVICES RENDERED

1. Fee for services $ _____
2. Total Down Payment $ _____
3. Unpaid Balance $ _____
4. Amount Financed $ _____
5. Finance Charge $ _____
6. Finance Charge (Expressed as Annual percentage rate 21%) $ _____
7. Total Payment Due (4 plus 5) $ _____
8. Total Charge $ _____

Total payment due (7 above) is payable to Dr Laci Rector, in _____ monthly payments of $ _____. The first installment is payable on _____, and each subsequent payment is due on the same of each consecutive month until paid in full. In the event any such installment or payment shall be more than 10 days late, the entire balance shall become immediately due. In the event the patient does not make payments as set forth herein, the patient agrees to pay all costs of collection agencies, attorney fees, court costs and office time and expense in attempting collection. The undersigned acknowledges receipt of dental services dental services by Laci D. Rector, DDS, PC. Both parties agree that there will be no interest, finance or carrying charge if the account is paid in full within sixty days from the date the service is performed, the entire debt being due and payable at the time of such service. The patient acknowledges that he (she) will be charged 1.75 percent per month Finance Charge (Annual Percentage Rate 21%) on the unpaid balance after the sixty-first day has expired and until the account is paid in full.
Both parties acknowledge that they have read this agreement and that the terms thereof are acceptable and agreeable to each.

DATED this _____day of _____, 20____.

_____
SIGNATURE OF PATIENT,
PARENT IF PATIENT IS A MINOR

_____
LACI D. RECTOR, DDS, PC

ROCKY MOUNTAIN
Family Dental

Laci D. Rector D.D.S., P.C. 2910 Big Horn Ave., Suite A Cody, WY 82414

(307)-587-5588

Failed Appointment/ Cancellation Policy

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have a **Failed Appointment/Cancellation Policy.** When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:
We require that you give our office **24 hours** notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $50.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled without the payment of this fee. Additionally, if a patient is more than **15 minutes** late without prior notice for a scheduled appointment, we will consider this a missed appointment and the **$50.00 cancellation fee** will be charged. We understand that situations do arise last minute, and there will be exceptions to this policy in those cases.

If you are a new patient and you fail your first appointment, this will result in having to make a $100.00 non-refundable deposit to reschedule your appointment. After that, if you make your appointment, the deposit will go towards that visit and/or future treatment.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have. We thank you for your patronage.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to its terms.

_____ _____

Signature of Patient Date