Smile Artists
Alvin W. Neff, DDS, FAGD

WELCOME

to the office of
Alvin W. Neff, DDS, FAGD
Cosmetic Dentistry

Patient Information

Patient Name: _____ Date: _____
LAST FIRST MI

Social Security #: _____ DL#: _____ Birth Date: _____

Phone (Home): _____ (Cellphone) _____ (Work) _____

Best time to call: _____ Emergency Contact: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Address: _____
STREET CITY STATE ZIPCODE

Email address: _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please, check those that apply

- ☐ Allergies _____ _____
- ☐ Allergic-Codeine
- ☐ Allergic-Penicillin
- ☐ AIDS
- ☐ Anemia
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer: Type _____
- ☐ Diabetes Insulin Dependent
- ☐ Dizziness
- ☐ Epilespy
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Hemophilia
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy Due Date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ TMJ Disorder
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Pre-med for: _____ _____
- ☐ HIV
- Other: _____ _____ _____

- Are you taking any medication at this time? Yes No
- If yes, please list: _____
- Are you now under the care of a physician? Yes No
- If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Are you having any sensitive teeth or dental problems at this time. Yes No
- Is there anything you would like to change about the appearance of your smile? Yes No
- If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

Referral Information

Whom may we thank for referring you to our practice? ☐ Another Patient, friend ☐ Another Patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ Citiscapes ☐ Radio ☐ Celebrate Magazine ☐ Other; _____

Name of person or office referring you to your practice:

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 Number: _____ Birth Date: _____

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

Address: _____
Street Apartment #

_____
City State Zipcode

Employment Information

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

Employer Name: _____ Occupation: _____

Address: _____
State City Zipcode

Dental Insurance Information

Primary

Name of Insured: _____ Is Insured a Patient? ☐ Yes ☐ No
Last First MI

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

Insured's Address: _____

Insured's Employer Name: _____

Address: _____

Patients 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: _____

Insured's Employer Name: _____

Address: _____

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 parents 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. 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.

A service charge of .83% per month (10% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

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 the Doctor, I agree to pay therefore the reasonable value of 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 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.

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

_____ _____ _____
Signature of patient, parent or guardian Date Relationship to Patient