DONALD S. HANSEN, D.D.S.
FINANCIAL POLICY

Thank you for choosing Dr. Hansen as your dental care provider. We are committed to your treatment being successful. Please understand that payment o your bill is considered part of your treatment. In an effort to inform our patients of our guidelines regarding payment for services, we have established a Financial Policy. We hope the policy is informative and helpful to you. We ask that you please read and sign the policy before receiving treatment.

Our payment options include cash, check, debit card, Visa, MasterCard and Discover credit cards.

Patients With Insurance. As a courtesy, we will file most insurance claims for you. All estimated co-pays and deductibles are due at time of treatment. Any amounts unpaid by the insurance company, are your responsibility. If your insurance company has not paid your account in full within 45 days, you will be billed for the outstanding amount due on your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered for payment under your insurance plan.

Patients Without Insurance. Adult patients are responsible for full payment at the time of service. Parents, guardians or adults accompanying minors are responsible for full payment at the time of service.

Broken Appointments, Interest, NSF Checks, Collections. We reserve the right to charge for broken appointments, if appointments are not canceled 24 hours in advance. We also reserve the right to charge interest on outstanding balances, as provided by State law. Bad checks are subject to be turned over to the State Attorney's office, and accounts will be assessed in accordance with state law. Accounts turned over to a collection agency will be charged for any collection fees involved. **Collections, bad debt write-offs and returned checks are cause for immediate dismissal from the practice.**

We look forward to providing you and your family with quality dental care. Again, thank you for choosing our practice, and please do not hesitate to let us know if you have questions or concerns.

I have read and understand the Policy. By signing below, I am accepting and agreeing to this Financial Policy.

X_____ Date _____

Signature of Patient or Responsible Party

DONALD HANSEN

MEDICAL – DENTAL HISTORY

PATIENT INFORMATION

Today's Date _____ Patient Name _____

Male ☐ Female ☐ Birth date _____ SSN _____

Marital Status____ Address _____

City _____ State____ Zip _____

Driver's License: _____ _____

Phone Numbers: Home_____ Work_____ Cell_____

Employer _____ Address _____

City_____ State____ Zip_____

How will you be paying for today's service? Cash☐ Check ☐ Credit Card ☐

PERSON RESPONSIBLE FOR ACCOUNT (IF DIFFERENT THAN PATIENT)

Name _____ Relationship_____

Birth date _____ SSN _____ Home Phone_____

Address (if different)_____

City _____ State____ Zip _____

Employed By _____ Occupation _____

Business Address _____

City_____ State____ Zip_____

Business Phone _____

DENTAL INSURANCE INFORMATION

Insurance Company _____ Group Number _____

Insurance Company Phone Number _____

Address for Claims_____

City_____ State____ Zip_____

Subscriber's Name_____ Relationship _____

Address (if different) _____

City_____ State____ Zip_____

Birth date _____ SSN _____ Home Phone_____

Employed By _____ Work Phone _____

Business Address _____

City_____ State____ Zip_____

Other dependents covered under this plan:

_____

PATIENT DENTAL AND MEDICAL HEALTH INFORMATION

Check the box if you have had problems with any of the following:

- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Grinding or clenching teeth
- ☐ Periodontal treatment
- ☐ Sores/growths
- ☐ Bad Breath
- ☐ Food collection between teeth
- ☐ Loose teeth or broken fillings
- ☐ Sensitivity ☐hot ☐cold ☐sweets ☐biting
- ☐ Fever blisters

How often do you brush?___ _____ How often do you floss?_____

How do you feel about the appearance of your teeth? _____

Do you smoke or use tobacco? ☐Yes ☐No

(over →)

Are you under a physician's care now? ☐Yes ☐No **Explain** _____

Physician Name _____ **Phone Number** _____

Have you had any hospitalizations and/or major operations? ☐Yes ☐No
Explain and list date(s) _____

Have you ever had serious head or neck injury? ☐Yes ☐No
Explain and list date(s) _____

Please list any medications you are taking now _____

Are you taking any BONE DENSITY medications, such as FOSAMAX, ACTONEL, AREDIA, ZOMETA, BONIVA, etc. If yes, list name of Medication _____

Are you taking aspirin, blood thinners, warfarin or plavix on a daily basis? ☐Yes ☐No
If yes, list name of Medication _____

Have you ever had any IMPLANTS, i.e., hip, knee, heart valve, etc.? ☐Yes ☐No
Explain and list date(s) _____

Have you ever been told to PRE-MEDICATE prior to any dental appointment? ☐Yes ☐No

Are you ALLERGIC to any medications or substances? ☐Yes ☐No
Please check the appropriate box:
☐*Aspirin* ☐*Penicillin* ☐*Codeine* ☐*Acrylic* ☐*Metal* ☐*Latex Rubber* ☐*Other* _____

Please CIRCLE the medical conditions listed below that apply to you

Abnormal Bleeding	Cardiac Transplantation	Headaches (frequent)	Low Blood Pressure	Sinus Problems
Alcohol Abuse	Colitis	Hearing Loss/Impairment	Leukemia	Stents
Allergies	Congenital Heart Defect	Heart Attack	Mitral Valve Prolapse	Stroke
Anemia	Cortisone Therapy	Heart Murmur	Osteoporosis	Thyroid Problems
Angina/Chest Pain	Cosmetic Surgery	Heart Surgery	Pacemaker	Tuberculosis
Arthritis	Diabetes	Hemophilia	Pain in Jaw Joints	Ulcers
Artificial Heart Valve	Drug Abuse	Hepatitis A☐ B☐ C☐	Psychiatric Problems	Venereal Disease
Artificial Joints	Emphysema	High Blood Pressure	Radiation	Yellow Jaundice
Asthma	Endocarditis	HIV+ AIDS	Rheumatic Fever	
Blood Transfusion	Epilepsy	Irregular Heartbeat	Seizures	
Breathing Difficulty	Fainting Spells	Kidney Problems	Shingles	
Cancer/Chemo	Glaucoma	Liver Disease	Sickle Cell Disease	

Please list any other conditions you have that are not listed above _____

If FEMALE: Are you taking Birth Control Pills? ☐Yes ☐No **If pregnant, # of weeks** _____
Are you pregnant? ☐Yes ☐No **Are you nursing?** ☐Yes ☐No

I certify the answers given are correct. I will report any changes in my health status or medications to Dr. Hansen and/or his staff. I accept full responsibility for payment for any and all charges incurred for dental treatment.

Patient Signature _____ **Date** _____
(Parent or Guardian)