

PATIENT HEALTH RECORD

UPDATE

Date _____

Please update any information that may have changed since your original visit:

Dr. Mr. Mrs. Ms. _____ Nickname _____
(last) (first) (initial)

Address _____
(street) (city) (state) (zip)

Home Phone (____) _____ Cell (____) _____ Business (____) _____

E-Mail _____

Married _____ (Spouse's name) _____ Single _____

Preferred Method of Contact: E-Mail ____ Cell ____ Home ____ Business ____

Occupation _____ Emergency Contact _____ Phone Number (____) _____

Is it OK if we send you periodic E-Mails highlighting new office developments and specials or rewards for our patients? Yes ____ No ____

MEDICAL HEALTH

Are there any recent changes to your medical health that we should be aware of, any new allergies, any surgeries, conditions, diseases or problems not previously listed, or any new medications you are taking, or medicine you stopped taking?

CANCELLATION POLICY

Dr. Kaiser operates as a full-service Dentist and makes herself available to her patients with a variety of scheduling options for their busy lives.

In consideration, please cancel or reschedule any appointments with our office with at least 48 hours of notice for Dr Kaiser and her staff.

Accordingly, patients that fail to show up for their appointments, or cancel with less than 48 hour notice, will be charged a service fee proportional to the originally scheduled treatment.

FINANCIAL ARRANGEMENTS

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients 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 services performed without previous financial arrangements, must be paid for via cash or credit card at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient's account and that he or she is personally responsible for payment of all dental services.

This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account.

However, patients will be responsible for any remaining balance not paid for by the insurance companies.

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

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

_____ Date: _____ Relationship to Patient _____
Signature of guarantor of payment/responsible party