Paul D. Herrera D. D. S.
Comprehensive and Implant Dentistry
645 Country Club Terrace
Lawrence, KS 66049

Date: _____

Patient Information

Patient Name: _____
Last First MI (Preferred Name)

Social Security #: _____ Birth date: _____ Age: _____
Address: _____
Number Street Apt # City State Zip Code

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____
Best time to call: _____ E-mail _____
Would you like email or text message reminders for future appointments? Circle your choice below
Opt IN Opt OUT

☐ Male ☐ Female ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor Child

☐ Student ☐ F/T ☐ P/T School: _____ Drivers License#: _____ State: _____

Emergency Contact: Name: _____ Address: _____
Phone: _____ Relationship: _____

Person Responsible for Payment

☐ Same As Above ☐ Husband ☐ Wife ☐ Father ☐ Mother ☐ Son ☐ Daughter ☐ Guardian
☐ Other _____

Name:_____
Last First MI
Address: _____
Number Street Apt # City State Zip Code
Social Security #: _____ Birth date: _____ Age: _____
Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____
Best time to call: _____

Method of Payment

☐ Insurance ☐ Credit Card ☐ Cash ☐ Check

Patient Employment Information

☐ Employed: ☐ F/T ☐ P/T ☐ Self-Employed ☐ Retired

Employer/Business Name:_____ Occupation: _____
Address:_____
Street City State Zip Code Phone

Referral Information

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

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice:_____

Dental Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth date: _____ Social Security #: _____

Insured's Address: _____
Street City State Zip Code
Insured's Employer: _____
Name Address Phone
Insurance Company: _____
Name Address
Insurance ID #: _____ Group #: _____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth date: _____ Social Security #: _____

Insured's Address: _____
Street City State Zip Code
Insured's Employer: _____
Name Address Phone
Insurance Company: _____
Name Address
Insurance ID #: _____ Group #: _____

Medical Insurance Information

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth date: _____ Social Security #: _____

Insured's Address: _____
Street City State Zip Code
Insured's Employer: _____
Name Address Phone
Insurance Company: _____
Name Address
Insurance ID #: _____ Group #: _____

Release

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
- I authorize release of any information concerning my (or my child's) heath care, advice and treatment to another dentist.
- I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
- I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.
- I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE: _____ DATE: _____

Paul D. Herrera D.D.D., P.A.
Comprehensive & Implant Dentistry
645 Country Club Terrace
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(785) 331-0027

Date: _____

DENTAL HISTORY

Are you having any discomfort at this time? _____

How long has it been since you have seen a dentist? _____

Have you had x-rays/images taken within the last 3-5 years? _____
If yes, by whom?

_____

Are your teeth sensitive to: Heat ____ Cold ____ Sweets ____ Pressure ____ Other____

Have you ever had gum treatments? _____ When? _____ By whom? _____

Do you currently have bleeding gums? ____ Does food wedge between your teeth? ____

If so, where? _____

Do you clench or grind your teeth? _____ When? _____

Have you had your teeth straightened? ____ When? _____By whom? _____

Do you feel you have bad breath at times? _____ When? _____

Do you have an unpleasant taste in your mouth? _____

Do you have any pain in or around your ears? _____ Do you hear popping, clicking or snapping when you chew? _____

Are there any lumps or swelling in your mouth?_____

Do you have a fear of dentistry? _____

ESTHETICS:

Are your teeth: Chipped? ____ Protruding? ____ Hidden? ____ Discolored? ____

Crooked? ____Large spaces? ____

Do you like the shape of your teeth? ____Are there any fillings, caps (crowns) you do not like looking at? _____Do you like your smile? _____ If not, why? _____

Do you feel that there is anything that you would like to add? _____

Rockledge Dentistry
Paul D. Herrera D.D.S, P.A.
Comprehensive & Implant Dentistry
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Lawrence, KS 66049
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Medical History

Patient Name: _____ Birth date: _____ Age: ____
Last First MI (Preferred Name)

Physician's Name: _____

Address _____

_____ Tel. _____

If you mark YES, please explain below.

1. Are you under a physician's care? ..... YES NO
   Last visit date: _____ Reason: _____
2. Have you ever had a serious illness or major surgery? ..... YES NO
3. Any artificial joints / prosthesis? ..... YES NO
4. Are you Diabetic? ..... YES NO
5. Do you have Liver problems to include testing positive for Hepatitis? ..... YES NO
6. Are you taking any medications? Please provide a list if possible ..... YES NO
7. Are you allergic to any medications or substances? ..... YES NO
8. Do you routinely take Herbs or other non-prescription remedies? ..... YES NO
9. Are you sensitive to any Metals or Latex? ..... YES NO
10. Do you have COPD (Chronic Obstructive Pulmonary Disease) ..... YES NO
11. Do you have asthma? ..... YES NO
12. Do you smoke, chew, use snuff or any other form of tobacco? ..... YES NO
13. Do you or have you had TB? ..... YES NO
14. Have you ever been treated for heart disease to include the following?
    +Pacemaker or Defibrillator ..... YES NO
    +Artificial heart valve? ..... YES NO
    +Rheumatic fever? ..... YES NO
    +Heart Murmurs with Regurgitation ..... YES NO
    +High or low blood pressure? ..... YES NO
15. Are you pregnant or suspect you may be? ..... YES NO
16. Do you take birth control medications? ..... YES NO
17. Radiation or chemo treatment for tumor, growth? ..... YES NO
18. Inflammatory disease, such as arthritis/rheumatism? ..... YES NO
19. Any blood disorders, such as anemia, leukemia, etc? ..... YES NO
20. Do you bleed excessively after being cut or injured? ..... YES NO
21. Do you have stomach problems? ..... YES NO
22. Do you have kidney problems? ..... YES NO
23. Do you have epilepsy or seizure disorders? ..... YES NO
24. Have you tested HIV positive? ..... YES NO
25. Do you have AIDS? ..... YES NO
26. Do you consume alcoholic beverages? ..... YES NO
27. Do you habitually use controlled substances? ..... YES NO
28. Have you had psychiatric treatment? ..... YES NO
29. Do you have any disease, condition, or problem not listed? ..... YES NO
30. Is there anything else we should know about your health that we have not covered in this form? _____
31. Would you like to speak to the Doctor privately about any problem? ..... YES NO

I certify that the above information is complete and accurate.

Update: _____

Patient / Guardian's signature _____ Date _____ Patient Sign _____

Dentist/s signature _____ Date _____ Dentist Sign _____

MED ALERT					ANESTH

Paul D. Herrera D.D.S., P.A.
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Financial Policy

As a condition of your treatment by this office, **financial arrangements must be made in advance**. The practice depends upon the reimbursement from the patients for the costs incurred in their care. Therefore, financial responsibility on the part of each patient must be determined before treatment.

INSURANCE/THIRD PARTY PAYMENTS:

1. **Our goal is to help you maximize your dental benefits.** As a courtesy to our patients, we are happy to bill your dental carrier for services rendered**.** Please remember that your employer and the insurance carrier have determined the benefits available under your dental contract. We do not have access to accurate benefit information unless you provide us a copy of your dental benefit booklet. We will attempt to determine your benefits via phone or Internet.

2. **Every patient's dental plan is different, and necessary dental services are not always covered**. Very few dental plans fully cover all dental services.

3. **W**hen estimating insurance coverage, we must also stress the word **estimate** as dental benefits are determined by each patient's dental contract.

4. **If your dental plan pays less than expected, a balance due will be reflected on your monthly statement. If your dental plan later determines that you were not eligible for coverage the balance becomes your responsibility**.

5. All patients with dental insurance must pay their **DEDUCTIBLE and / or CO-PAYMENT at the time a service is rendered. Financial arrangements for insurance co-payments must be made in advance.**

CASH/CHECK or CREDIT CARD PAYMENTS

1. Payment is due on day treatment is rendered.
2. **In cases involving laboratory services (Crowns, Bridges, Partials, Dentures, etc.), ONE-HALF of the total cost is due the day services are started.** The balance of the account is due in full the day of completion unless otherwise arranged with the Business Manager prior to the beginning of treatment.
3. If I make a payment by check and it is returned for any reason I agree to pay a charge of **$30.00** for each returned check, along with all fees associated with collection.
4. **VISA, MASTERCARD and DISCOVER ACCEPTED**.

PAYMENT PLANS

1. Offered through the **CARE CREDIT** program.
2. No initial down payment or annual fees.
3. Low monthly payments.
4. ***Good credit standing required***.

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Financial Policy (Continued)

- **All emergency dental services** performed without previous financial arrangements, **must be paid for in cash at the time services are performed.**

- A service charge of 1 ½% [per month (18% annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

- In consideration for the professional services rendered to me, or at my request, by Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time of services are rendered, or within (5) days of billing if credit shall be extended. I further to agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment there of. 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 cost and reasonable attorney fees if suit were instituted hereunder.

I understand the financial policies of this office and agree to pay for treatment that I receive.

_____ _____
(Signature) (Date)

_____ _____
(Print Name) (Date)

ROCKLEDGE DENTISTRY

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Comprehensive & Implant Dentistry
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Lawrence, KS 66049
(785) 331-0027

Date: _____

SIGNATURE ON FILE

Patients Name: _____
Last First MI

I hereby authorize payment directly to Paul D. Herrera, D.D.S., P.A., of the dental benefits otherwise payable to me.

_____
Signature (Insured Person) Date

Signature is valid for two years from the above date, unless revoked by me at an earlier date.

Additionally, Paul D. Herrera, D.D.S., P.A, is authorized to provide any insurance company(s), claim administrator(s) and consulting health care professionals, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.

This authorization is valid for the term of coverage of the policy or contract, in force on this date only, or for two years, which ever is shorter.

I know I have a right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

_____
Patient or Authorized Person Signature Date