Financial Agreement

1. I agree to pay the amount charged by Le Sueur Family Dental for all professional treatment and services to the patient listed below.

2. I authorize Le Sueur Family Dental to furnish to my dental or health insurance company all the information which said company may request concerning treatment for myself and/or dependents.

3. I assign to Le Sueur Family Dental the dental and/or medical-surgical benefits to which I or my dependents are entitled to under my dental or health insurance. I understand that I am financially responsible for all charges.

4. I agree to make payment in full for all charges within 60 days of date of service unless a written financial agreement has been made in advance.

5. I agree to pay Le Sueur Family Dental FINANCE CHARGES on any unpaid balance over 60 days old at the rate of 1.5% per month (18% annually).

6. I can avoid any finance charges by paying my account balance in full within 60 days of service.

7. I understand and agree that if my account should become delinquent, that I will pay all reasonable legal fees, court cost and other costs necessary to collect the debt, including fees charged by a collection agency.

Authorization for Treatment

Please read and sign the following statement:

I authorize and request the performance of dental treatment for myself and dependents and give my consent to any advisable and necessary dental procedures, medications, anesthetics or analgesics to be administered by Le Sueur Family Dental Staff.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold the staff of Le Sueur Family responsible for any errors and/or omissions that I may have made in the completion of this form.

I have read, understand and agree to the terms of the financial agreement on this form.

Please do not sign this before you read the financial agreement. Please ask for a copy of this agreement.

_____ _____

Name of Patient Date of Birth

_____ _____ _____

Signature Relationship Date

Welcome

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

We offer a 5% discount on payment in full for same day services.

Date_____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate_____ Home Phone_____

Address_____ City_____ State_____Zip_____

Check Appropriate Box: ☐Single ☐Married ☐ Divorced ☐ Widowed ☐Separated Cell _____

If Student, Name of School/College_____ City_____ State_____ ☐ Full Time ☐ Part Time

Patient's or Parent's Employer_____ Work Phone_____

Business Address_____ City_____ State_____Zip_____

Spouse or Parent's Name_____ Employer_____ Work Phone_____

Whom May We Thank for Referring You? _____

Person to Contact in Case in Emergency_____ Phone_____

Responsible Party

Name of Person Responsible for this Account_____ Relationship to Patient_____

Address_____ Home Phone_____ Birthdate_____

Employer_____ Work Phone_____ SS#_____

Is this Person Currently a Patient in our Office? ☐Yes ☐ No

Insurance Information

Name of Insured_____ Relationship to Patient_____

Birthdate_____ Social Security #_____ Date Employed_____

Name of Employer_____ Union or Local #_____ Work Phone_____

Address of Employer_____ City_____ State_____Zip_____

Insurance Company_____ Group #_____ Policy/ID #_____

Ins. Co. Address_____ City_____ State_____Zip_____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit_____

DO YOU HAVE ADDITIONAL INSURANCE? IF YES, COMPLETE THE FOLLOWING:

Name of Insured_____ Relationship to Patient_____

Birthdate_____ SS#_____ Union or Local #_____ Date Employed_____

Name of Employer_____ Address_____

Insurance Company_____ Group #_____ Policy/ID#_____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit_____

OVER PLEASE

Patient Medical History

Physician_____ Office Phone_____ Date of Last Exam_____

1. Are you under medical treatment now?..... Yes / No
2. Have you ever been hospitalized for any surgical operation or serious illness?..... Yes / No
   If yes, please explain_____
   _____
3. Are you taking any medication(s) including non-prescription medicine?..... Yes / No
   If yes, please list all medication(s) you're taking including any herbal supplements.
   _____
   _____
4. .Have you ever taken Phen-Fen/Redux?..... Yes / No
5. Do you use tobacco?..... Yes / No
6. Do you use controlled substances?..... Yes / No
7. Do you have or have you had any of the following?

High blood pressure..... Yes / No	Heart Disease..... Yes / No	Chest Pains..... Yes / No
Heart Attack..... Yes / No	Cardiac Pacemaker..... Yes / No	Easily Winded..... Yes / No
Rheumatic Fever..... Yes / No	Heart Murmur..... Yes / No	Stroke..... Yes / No
Swollen Ankles..... Yes / No	Angina..... Yes / No	Hay Fever/Allergies..... Yes / No
Fainting/Seizures..... Yes / No	Frequently Tired..... Yes / No	Tuberculosis..... Yes / No
Asthma..... Yes / No	Anemia..... Yes / No	Radiation Therapy..... Yes / No
Low Blood Pressure..... Yes / No	Emphysema..... Yes / No	Glaucoma..... Yes / No
Epilepsy/Convulsions..... Yes / No	Cancer..... Yes / No	Recent Weight Loss..... Yes / No
Leukemia..... Yes / No	Arthritis..... Yes / No	Liver Disease..... Yes / No
Diabetes..... Yes / No	Joint Replacement..... Yes / No	Heart Trouble..... Yes / No
Kidney Disease..... Yes / No	Hepatitis/Jaundice..... Yes / No	Respiratory Problems... Yes / No
AIDS or HIV Infection..... Yes / No	STD's..... Yes / No	Mitral Valve Prolapse.... Yes / No
Thyroid Problem..... Yes / No	Stomach Troubles/Ulcers.. Yes / No	Other_____ Yes / No

8. Are you allergic to or have you had any reactions to the following?
   - Local Anesthetics (ex. novocaine)..... Yes / No
   - Penicillin or other Antibiotics..... Yes / No
   - Sulfa Drugs..... Yes / No
   - Barbiturates..... Yes / No
   - Sedatives..... Yes / No
   - Aspirin..... Yes / No
   - Any Metals (ex. nickel, mercury, etc.)..... Yes / No
   - Latex Rubber..... Yes / No
   - Other (please list)_____ Yes / No
9. Women Only:
   a) Are you pregnant or may be pregnant?.. Yes / No
   b) Are you nursing?..... Yes / No
   c) Are you taking oral contraceptives?..... Yes / No

Patient Dental History

Name of Previous Dentist and Location_____Date of Last Exam_____
Why did you leave this Dentist?_____

1. Do your gums bleed while brushing and flossing?..... Yes / No
2. Are your teeth sensitive to hot or cold liquids/foods?.... Yes / No
3. Are your teeth sensitive to sweet or sour?..... Yes / No
4. Do you feel pain to any of your teeth?..... Yes / No
5. Do you have any sores or lumps in or near your mouth? Yes / No
6. Have you had any head, neck or jaw injuries?..... Yes / No
7. 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
8. Do you have frequent headaches?..... Yes / No
9. Do you clench or grind your teeth?..... Yes / No
10. Do you bite your lips or cheeks?..... Yes / No
11. Have you had any difficult extractions in the past?..... Yes / No
12. Have you any prolonged bleeding following extractions?..... Yes / No
13. Have you had orthodontic treatment... Yes / No
14. Do you wear dentures or partials..... Yes / No
15. Have you ever received oral hygiene instructions?..... Yes / No
16. Do you like your smile?..... Yes / No
    If not, what would you change?
    _____

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 harmful to my health. I authorize the dentist to release any information rendered to me or my child 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 payable 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 rendered on my behalf or my dependants.

X_____ Date_____

Signature of patient (or parent if minor)

INSURED

Authorization for Signature on File / Authorization for payment

I _____ hereby authorize the office of Le Sueur Family Dental to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my employment with_____.

I hereby authorize the payment of dental benefits otherwise payable to me, directly to the office of Le Sueur Family Dental.

The "Signature on File" will be valid from this date forward, unless written cancellation is given.

_____ _____ _____

Date Signature of Insured Witness

PATIENT

Authorization for Signature on File / Release of Information & Financial Responsibility

I _____ hereby authorize the office of Le Sueur Family Dental to affix my name to any and all claims or documents as related to any and all health benefits due me.

I have reviewed the following treatment plans and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law. I authorize release of any information related to this claim.

This "Signature on File" will be valid from this date forward, unless written cancellation is given.

_____ _____ _____

Date Patient Name Signature

_____ _____ _____

Relationship, if minor Parent Signature Witness