Kopper Family Dental, P.A.

15 7th Ave NW • Rochester, MN 55901

Patient Information

Patient Name: _____ Date: _____
Last First MI

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

Birth Date: _____ E-mail address:_____

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

Address: _____
Street Apartment #

_____
City State Zip Code

How did you find out about our practice? _____

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

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

☐HIV
☐Allergies _____
_____
☐Anemia
☐Arthritis
☐Artificial Joints
☐Asthma
☐Cancer
☐Diabetes
☐Epilepsy
☐Excessive Bleeding
☐Fainting
☐Glaucoma
☐Gastrointestinal
☐Head Injuries
☐Heart Disease
☐Heart Murmur
☐Hepatitis
☐High Blood Pressure
☐Kidney Disease
☐Liver Disease
☐Mental Disorder
☐Pacemaker
☐Pregnancy
☐Due date: _____
☐Radiation Treatment
☐Respiratory Problems
☐Rheumatic Fever
☐Sinus Problems
☐Stomach Problems
☐Stroke
☐Tuberculosis
☐Tumors

OTHER (Any major diagnosis):

☐_____

☐_____

- Have you ever had any complications following dental treatment? ☐Yes ☐No
  If yes, please explain:_____
- Do you have any health problems that need further clarification? ☐Yes ☐No
  If yes, please explain:_____

Please list all medications:

Drug Name	Dosage	Indication	Start date:	Stop date:	Oral side effects:

I have read the conditions for treatment and payment at the bottom of the next page 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

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Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Patient Name: _____ Date: _____
Last First MI

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

Birth Date: _____ E-mail address: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

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

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

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

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

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Consent for Services and Payment

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have a change in my health, I will inform the Doctor at my next appointment.

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 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, unless prior special arrangements have been made. This office will help prepare patient's 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 1½% per month (18% 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 services to 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 the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. 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.

Kopper Family Dental reserves the right to terminate the Doctor/Patient relationship or charge $50.00 if I fail appointments and do not provide 24hrs notice.

I grant my permission to you or your assignee, to telephone me at home or at my work to remind me of appointments and or discuss matters related to this form.