Stacy N. Butler, DDS LLC
Bristol Dental Associates

*Welcome to our office, we sincerely appreciate you choosing us for your dental health needs. We're here to serve and care for you. Your best interests are our chief concern.*

## Patient Information:

Name (Last, First, Middle): _____ Preferred Name: _____

Gender: _____ Preferred Pronoun: _____ Date of Birth: _____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Email: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____

Referred By: _____

## Emergency Contact:

Full Name: _____ Relationship: _____ Contact Number: _____

Full Name: _____ Relationship: _____ Contact Number: _____

## Primary Dental Insurance Coverage (If Applicable)

Subscriber Name: _____ Relationship to Patient: _____

Address: _____

Date of Birth: _____ Social Security Number: ____/____/_____ Employer: _____

Insurance Company: _____ Insurance ID#: _____ Group #: _____

Insurance Address: _____

## Secondary Dental Insurance Coverage (If Applicable)

Subscriber Name: _____ Relationship to Patient: _____

Address: _____

Date of Birth: _____ Social Security Number: ____/____/_____ Employer: _____

Insurance Company: _____ Insurance ID#: _____ Group #: _____

Insurance Address: _____

## Responsible Party

I understand that payment for services is due and payable at the time of service and is my responsibility, unpaid balances will accrue interest at the rate of **1 ½% per month (18% per annum).** I also understand that my dental insurance is a contract between me and my insurance carrier. I further agree to pay any and all costs of collection, legal or other fees required should I fail to meet my financial obligations in a timely manner. I authorize Bristol Dental Associates to send me postcards with appointment information and leave me telephone messages regarding same and any copays due from me at my home, cell or work. I also, by my signature below, authorize Bristol Dental Associates and its employees or agents to release/discuss any dental or medical information necessary to institute or enable processing of a claim of any nature to any insurance company or course of treatment with specialist or other health care providers and also authorize payment directly to Bristol Dental Associates or its designees.

Signature: _____ Date: _____

# PATIENT MEDICAL HISTORY

**Patient's Name:**

**For Office Use Only**
**ID:**

**Address:** | **Today's Date:** | **Date of Last Visit:** | **Date of Med. History:**

**City State Zip:** | **Email:**

**Home Phone:** | **Work Phone:** | **Cell Phone:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

**Primary Dental Guarantor:** | **Home Phone:** | **Work Phone:** | **Cell Phone:**

**Secondary Dental Guarantor:** | **Home Phone:** | **Work Phone:** | **Cell Phone:**

**Physician Name:** | **Physician Phone:**

**Pharmacy:** | **Pharmacy Phone:**

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**For Office Use Only**
**Medical Alerts:**

**Sex:**

**If female please answer the following:**

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks ☐
- ☐ ☐ Are you nursing?

**Please answer the following:**

Y N
- ☐ ☐ Do you smoke or use tobacco?

**For Office Use Only**
BP ☐ Heart Rate: ☐

Height: ☐
Weight: ☐

| Y | N | Conditions |
|---|---|---|
| ☐ | ☐ | Abnormal Bleeding |
| ☐ | ☐ | Alcohol Abuse |
| ☐ | ☐ | Allergies |
| ☐ | ☐ | Anemia |
| ☐ | ☐ | Angina Pectoris |
| ☐ | ☐ | Arthritis |
| ☐ | ☐ | Artificial Bones |
| ☐ | ☐ | Artificial Heart Valve |
| ☐ | ☐ | Asthma |
| ☐ | ☐ | Blood Transfusion |
| ☐ | ☐ | Cancer- Chemotherapy |
| ☐ | ☐ | Congenital Heart Defect |
| ☐ | ☐ | Cosmetic Surgery |
| ☐ | ☐ | Diabetes |
| ☐ | ☐ | Difficulty Breathing |
| ☐ | ☐ | Drug Abuse |
| ☐ | ☐ | Emphysema |
| ☐ | ☐ | Epilepsy |
| ☐ | ☐ | Fainting Spells |
| ☐ | ☐ | Fever Blisters |
| ☐ | ☐ | Frequent Headaches |
| ☐ | ☐ | Glaucoma |

| Y | N | Conditions |
|---|---|---|
| ☐ | ☐ | Hay Fever |
| ☐ | ☐ | Heart Attack |
| ☐ | ☐ | Heart Surgery |
| ☐ | ☐ | Hemophilia |
| ☐ | ☐ | Hepatitis A |
| ☐ | ☐ | Hepatitis B |
| ☐ | ☐ | High Blood Pressure |
| ☐ | ☐ | HIV+ AIDS |
| ☐ | ☐ | Kidney Problems |
| ☐ | ☐ | Liver Disease |
| ☐ | ☐ | Low Blood Pressure |
| ☐ | ☐ | Mitral Valve Prolapse |
| ☐ | ☐ | Pace Maker |
| ☐ | ☐ | Pneumocystitis |
| ☐ | ☐ | Psychiatric Problems |
| ☐ | ☐ | Radiation Therapy |
| ☐ | ☐ | Rheumatic Fever |
| ☐ | ☐ | Seizures |
| ☐ | ☐ | Shingles |
| ☐ | ☐ | Sickle Cell Disease |
| ☐ | ☐ | Sinus Problems |
| ☐ | ☐ | Stroke |

| Y | N | Conditions |
|---|---|---|
| ☐ | ☐ | Thyroid Problems |
| ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | Ulcers |
| ☐ | ☐ | Venereal Disease |
| ☐ | ☐ | Yellow Jaundice |
| ☐ | ☐ | Heart Murmur |

| Y | N | Allergies |
|---|---|---|
| ☐ | ☐ | Aspirin |
| ☐ | ☐ | Codeine |
| ☐ | ☐ | Dental Anesthetics |
| ☐ | ☐ | Erythromycin |
| ☐ | ☐ | Jewelry |
| ☐ | ☐ | Latex |
| ☐ | ☐ | Metals |
| ☐ | ☐ | Penicillin |
| ☐ | ☐ | Tetracycline |

**Other**

_____

_____

_____

**Medications:**

| | | |
|---|---|---|
| | | |

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

**Notes:**

**Signature:** _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

# Bristol Dental Associates

## PATIENT AGREEMENT

**CURRENT INSURANCE CARD/PHOTO ID: ALL** patients must present a current insurance card and a valid photo identification card (state issued driver's license or identification card) to be scanned into the patient medical record. If the patient being treated is a minor the parent or guardian financially responsible must present their insurance card and photo identification. ***If we are unable to verify insurance prior to your visit, payment is due in full when the service is provided.***

**APPOINTMENTS:** 24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation fee may then be added to your account. The fee charged for missing an office visit is $60. This fee is not covered by insurance and will be billed directly to the patient or guarantor.

**PAYMENT POLICIES:**
Your insurance policy is a contract between you and your insurance company. We are not responsible for, or in control of what services your insurance company will pay for or the amount your insurance company will reimburse for services rendered. You are responsible for the payment of any amount that your insurance carrier deems to be co-insurance or deductible. Due to our contractual obligations with your insurance company, we are not able to write off either co-insurance or deductibles.

**ACCOUNT BALANCES:** All balances billed to you are due upon receipt. If you choose to delay payment you will incur billing charges. Accounts that are 90 days past due will be turned over to a collection agency or small claims court. All fees associated with the collection of the debt will be added to the outstanding amount and will be your responsibility. **Delinquent accounts are reported to the major credit bureaus by the collection agency.** If you establish a payment plan we will keep a record of your credit card on file and you authorized Bristol Dental Associates to bill your credit card in the event that you do not make your payment by the agreed upon terms.

**PATIENT RESPONSIBLE CHARGES:** If you do not have insurance coverage or you are purchasing non-covered services or items, payment is due in full at the time of service. Payment may be made by cash or credit card. We accept Visa, MasterCard, American Express and Discover.

**NSF CHARGE:** $35 will be charged if a personal check is returned due to "insufficient funds" and a different form of payment will be expected for past balances and future services rendered.

**DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS:** The parent who brings the minor child to the appointment is responsible for payment of services rendered. Bristol Dental Associates will not be involved with separation or divorce disputes.

Name:_____ Signature: _____ Date: _____