Gregory S Imhoff D.M.D.
FINANCIAL POLICY

Patient(s) Name: ____

As a courtesy and added benefit to our patients with insurance, we are more than happy to file your insurance for you. However, we do require that you pay the estimated percentage your insurance does not cover plus any deductible at the time of your appointment.

I ____________________, understand that I am ultimately responsible for all costs of dental treatment *unless other arrangements have been made, in writing, before the date of treatment.*

Accounts past due more than 30 days *will generate a monthly 1.5% interest or 18% APR charge to the balance, personally due from you.*

Returned checks *will have a minimum charge of $30.00. Thereafter the balance is due in full with either a credit card or cash.*

Broken appointment fee of $50.00 *per hour will automatically* **be charged to the credit card** *on file for patients who fail to keep or reschedule appointments without a 48hour notice.*

In the event a delinquent account is placed for collection*, you will be responsible for all fees incurred in the collection of the debt.*

If you ask for credit and/or have an outstanding balance, you hereby authorize us to check your credit and employment history. We may also answer questions about your credit experience with us. Casanova and Imhoff D.M.D.,P.A. has the option to report your account status to any credit reporting agency such as a credit bureau.

If you have insurance **please read** *this important information:*

Casanova and Imhoff are not in contract with any insurance company other than Delta Dental Premiere plan. Any other plan will apply if your policy offers you the freedom to choose someone outside the network.

On your first visit we will call your insurance company to verify your benefits and will review your treatment plan with you. Since insurance companies change their payment schedules, **we cannot guarantee they will actually pay the estimated amount.**

Please understand that an ***insurance policy is not a "pay all," it is only an assistance in your dental care. You are ultimately responsible for all cost of your dental treatment.*** *Your insurance company has a responsibility to you, not us; therefore you must pursue the issue with them. We have no control over how they make their decisions, and you, as the patient with benefits, can make a difference. Please contact the insurance company immediately if there are any concerns. We will extend this credit for 60 days. After that our office policy requires you pay the balance in full.*

Most insurance companies pay a percentage of what they consider to be a customary fee for services. *Therefore your portion may be more than the estimated amount on your treatment plan. Benefits may vary considerably from one plan to the next and are subject to eligibility; plan limitations, yearly maximums, and benefits used. The range of benefits depends entirely on what extent of coverage (extensive or minimal) the purchaser wishes to offer employees or members.*

This practice has made an ethical decision to place composite (tooth colored) fillings instead of the mercury (silver) fillings. ***Your policy may either not pay for the composite fillings or may offer you an alternate benefit.*** *It is very important for you to know how your policy works and its benefits.*

If you have any questions, please do not hesitate to ask before we begin any dental treatment.

Responsible Party's Name ______________________ ***Relationship to Patient*** ______________
Responsible Party's S.S. # ______________________ ***D.O.B.*** ______________
I understand that I am ultimately responsible for all costs incurred. If insurance applies, I understand that I am ultimately responsible for any balance remaining after insurance has processed and completed the claims.

Signature ______________________________ ***Date*** ______________

MEDICAL HISTORY FORM

Date__________________

Name ____ Preferred Name ____________________
First Middle Last

Address ____________________________ City __________________ State____ Zip________

Home Phone ( ) ________________ Cell # ( ) ________________ Business Phone ( ) ____________

Date of Birth ____________ Single___ Married___ Div___ Widowed______ Social Sec #____________________

Name & Address of Employer ____________________ Occupation__________ City__________ State___ Zip________

Closest relative not in residence ______________ Phone( ) ________ Name of Spouse ____________ Cell # ( ) ________

Social Sec # of Spouse __________________ Spouse's Occupation & Employer ____________________________

Address of Employer __________________________________ City______________ State____ Zip________

Personal E-Mail ______________________________________ Referred by ______________________________

If completing this form for another person, what is your relationship to that person? ________________________________

For the following questions, circle yes or no. Your answers are for our records only and are considered confidential. During your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional question concerning your health.

1. Are you in good health? .... Yes No
2. Have there been any changes in your health within the past year? .... Yes No
3. My last physical examination was on ________________________________
4. Are you now under the care of a physician? .... Yes No
   If so, what is the condition being treated? ________________________________
5. The name and address of my physician(s) is ________________________________
   ____
   ____
6. Have you had any illness, operation, or been hospitalized in the past 5 years? .... Yes No
   If so, what was the illness or problem? ________________________________
7. Are you taking any medicine(s) including non-prescription medicine? .... Yes No
   If so what medication(s) are you taking? ________________________________
8. Do you have or have you had any of the following diseases problems?
   a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease .... Yes No
   b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, low blood pressure, arteriosclerosis, stroke) .... Yes No
      1. Do you have chest pain upon exertion? .... Yes No
      2. Are you ever short of breath after wild exercise or when lying down? .... Yes No
      3. Do your ankles swell? .... Yes No
      4. Do you have inborn heart defects? .... Yes No
      5. Do you have a cardiac pacemaker? .... Yes No
   c. Allergy .... Yes No
   d. Sinus trouble .... Yes No
   e. Asthma or hay fever .... Yes No
   f. Fainting spells or seizures .... Yes No
   g. Persistent diarrhea or recent weight loss .... Yes No
   h. Diabetes .... Yes No
   i. Hepatitis, jaundice or liver disease .... Yes No
   j. AIDS or HIV infection .... Yes No
   k. Thyroid problems .... Yes No
   l. Respiratory problems, emphysema, bronchitis, etc. .... Yes No
   m. Arthritis or painful swollen joints .... Yes No
   n. Stomach ulcer or hyperacidity .... Yes No
   o. Kidney trouble .... Yes No
   p. Tuberculosis .... Yes No
   q. Persistent cough or that produces blood .... Yes No
   r. Persistent swollen glands in neck .... Yes No
   s. Sexually transmitted disease .... Yes No
   t. Epilepsy or other neurological disease .... Yes No

u. Problems with mental health .... Yes No
v. Problems of the immune system .... Yes No
w. Artificial joints .... Yes No

9. Have you had abnormal bleeding? .... Yes No
   a. Have you ever required a blood transfusion? .... Yes No
   b. Have you ever taken Coumadin or Plavix? .... Yes No
10. Do you have any blood disorder such as anemia? .... Yes No
11. Have you ever had any treatment for a tumor or growth (including radiation therapy)? .... Yes No
12. Are you allergic or have you had a reaction to:
   a. Local anesthetics .... Yes No
   b. Penicillin or other antibiotics .... Yes No
   c. Sulfa drugs .... Yes No
   d. Barbiturates, sedatives, or sleeping pills .... Yes No
   e. Aspirin .... Yes No
   f. Iodine .... Yes No
   g. Codeine or other narcotics .... Yes No
   h. Latex .... Yes No
   i. Other ____________________
13. Have you ever taken Fen-phen, redux or any form of these medications? .... Yes No
14. Have you ever taken Fosamax, Actonel, Aredia, Zometa or any other bisphosphonate medication used to prevent bone loss.. Yes No
15. Have you had any serious trouble associated with any previous dental treatment? .... Yes No
16. Do you have any disease, condition, or problem not listed above that you think I should know about? .... Yes No
17. Are you wearing contact lenses? .... Yes No
18. Are you wearing removable dental appliances? .... Yes No
19. Do you smoke? What do you smoke? ____________ How many per day? ____________ Yes No

Women

20. Are you pregnant? .... Yes No
21. Do you have any problems associated with your menstrual period? .... Yes No
22. Are you nursing? .... Yes No
23. Are you taking birth control pills? .... Yes No

Chief Dental Complaint ____________________

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

____
Signature of Patient

For completion by the dentist.

Comments on patient interviews concerning medical history: ____________________

____

____

____

____________________ (Date) ____________________ Signature of Dentist

Medical history update:

Date	Comments	Signature

Gregory Imhoff D.M.D.

Cancellation Notice

Recently, we have had some challenges with patients not Understanding our guidelines on canceling appointments. We require that if you are unable to keep you're scheduled Appointment, that you give us 48 hours notice. In that way, we Are able to provide an opportunity for another patient to Benefit from that appointment time.

Please be advised that there is a $50 per hour fee for missed Appointments or short notice cancellations.

Date ___________

I understand and agree to adhere with Dr. Imhoff's Office policy regarding 48 hour notice for Cancellations.

______________________________ Printed name

______________________________ Signature of patient/parent