Florissant Dental Services LLC

John R. Landgraf DMD
504 New Florissant Rd. N Florissant, MO 63033
314-831-8500

Patient Information-Child

Patient Name: _____ Date:_____
Last First MI

Preferred first name or nick name:_____ ☐ Male ☐ Female

Child's Social Security #: _____-_____-_____ Birth Date:_____

Phone (Home): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Favorite hobbies, sports, or other activities_____

Responsible Party Information

The person responsible for payment is ___Mother ___Father ___Other

Mother's full name_____
Last First MI

Social Security #: _____-_____-_____ Birth Date:_____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Employer's Name: _____ Occupation:_____

Address: _____
Street City State Zip Code

Father's full name_____
Last First MI

Social Security #: _____-_____-_____ Birth Date:_____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Employer's 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:_____

_____

Is there a secondary insurance company?_____

Is this their first visit? **YES** or **NO** (circle one) If **NO**, who was their previous dentist? And when was their last visit? Were x-rays taken at that time?_____

_____

Health Information

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

- ☐ AIDS
- ☐ Allergies _____ (list) _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints or Valves
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head/Jaw Trauma
- ☐ Heart Disease
- ☐ Heart Murmur or mitral valve prolapse
- ☐ Hepatitis
- ☐ Hi/Lo Blood Pressure
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease

Medication current list

_____
_____
_____
_____
_____

Medicine Allergy (list)

_____

- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Sulfa allergy
- ☐ Pacemaker
- ☐ **Pregnant** Due date_____
- ☐ Nursing an infant
- ☐ Premedicate antibiotics
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Smoke
- ☐ Surgery: type & when _____
- ☐ Transfusion of blood
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

OTHER:

- ☐ _____

- **Have you ever had any complications following dental treatment?** ☐ Yes ☐ No
  If yes, please explain:
  _____
- **Have you been admitted to a hospital or needed emergency care during the past two years?** ☐ Yes ☐ No
  If yes, please explain:_____
- **Are you now under the care of a physician?** ☐ Yes ☐ No
  If yes, please explain:_____
- **Name of Physician:** _____Phone:_____
- **Do you have any health problems that need further clarification?** ☐ Yes ☐ No
  If yes, please explain:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct.
If I ever have any change in my health, I will inform the doctors at the next appointment without fail.
I hereby authorize any physician, medical practioner, hospital, clinic or medically related facility, the Medical Information Bureau, insurance company, or other organization or institution or person that has any records or knowledge of me, or my health, to give to John R. Landgraf DMD any such information.

Consent for Services

-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. This office will help prepare the patients 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. I understand that if my account gets turned over to collections I incur the 35% lawyer fees. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form., my dental care or any financial matters.

-I understand that all missed appointments or appointment changes made with less than 24 hours notice, will incur a fee of $27.00

-I have been offered a copy of this office's Notice of Privacy Practices.

I hereby authorize the release of any information required to complete my insurance claims and further authorize payment directly to John R. Landgraf DMD or his assignee, for any benefits otherwise payable to me for professional services rendered by this office. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. A copy of this authorization may be used in place of the original.

-I have read the above conditions of treatment and agreements and agree to their content.

⊗_____ Date: _____ Relationship to Patient:_____
Signature of patient, parent or guardian