GENERATIONS
Dental Care

Patient: _____
Date: _____

PATIENT INFORMATION

First Name: _____ Last Name: _____
Birth Date: _____ Gender: ◯ Male ◯ Female
Address: _____
City: _____ State: _____ ZIP _____
Email: _____ Cell Phone: _____
Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Other
Emergency Contact: _____ Phone: _____
Previous Dentist: _____ Dental Office: _____
Employer: _____

How did you hear about us?

◯ I live/work in area ◯ Referred by _____ ◯ Social media ◯ Other _____

MEDICAL HISTORY

◯ Alcohol or Drug Dependency
◯ Allergies (Latex, Food, Medication, Anesthesia)
◯ Anemia
◯ Anxiety or Depression
◯ Arthritis
◯ Artificial Heart Valve
◯ Artificial Joints (Hip, Knee, etc.)
◯ Asthma
◯ Bleeding Disorder
◯ Blood Transfusions
◯ Cancer
◯ Chemotherapy or Radiation Therapy
◯ Chest Pain (Angina)
◯ COPD (Chronic Obstructive Pulmonary Disease)
◯ Diabetes (Type I or II)
◯ Dizziness or Fainting
◯ Emphysema
◯ Epilepsy or Seizures
◯ GERD / Acid Reflux
◯ Glaucoma
◯ Head or Neck Injuries
◯ Hearing Loss
◯ Heart Attack
◯ Heart Disease or Failure
◯ Heart Murmur
◯ Hepatitis (A, B, or C)
◯ High Blood Pressure
◯ HIV/AIDS
◯ Immune Disorders
◯ Kidney Disease or Dialysis
◯ Liver Disease
◯ Mental Health Disorders
◯ Mitral Valve Prolapse
◯ Osteoporosis
◯ Pacemaker or Defibrillator
◯ Pregnant or Nursing
◯ Psychiatric Treatment
◯ Rheumatic Fever
◯ Sinus Problems
◯ Sleep Apnea or CPAP use
◯ Stroke
◯ Thyroid Condition
◯ Tobacco Use
◯ TMJ
◯ Tuberculosis (TB)
◯ Ulcers or Digestive Conditions

Current Medications: _____
Allergies: _____
Are you currently under a physician's care? _____
Physician: _____ Phone: _____

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HIPAA

By signing this form, you consent to the use and disclosure of your PHI for the purposes of treatment, payment, and healthcare operations.
You also acknowledge that you have received or been offered a copy of our Notice of Privacy Practices.
You may revoke this consent in writing at any time. Revocation will not apply to actions already taken in reliance on your consent.
A full document is available upon my request.

FINANCIAL POLICY

At Generations Dental Care, we are committed to providing the highest quality dental care in a compassionate and transparent manner. To ensure clear communication and avoid misunderstandings, we ask all patients to review and acknowledge the following financial policy.

Payment Responsibility
Payment is due in full at the time of service unless prior arrangements have been made.
The person who signs the consent for treatment is legally responsible for all charges.
We accept cash, credit/debit cards, and HSA/FSA cards.

Insurance
As a courtesy, we will submit insurance claims on your behalf. However, we cannot guarantee any coverage or benefits.
You are responsible for understanding your insurance plan, including deductibles, co-pays, and exclusions.
Any portion not covered by your insurance (including estimates) is your responsibility and due at the time of service.
If your insurance has not paid within 60 days, the balance becomes your responsibility.

Missed Appointments & Cancellations
Please provide at least 24 hours' notice if you need to cancel or reschedule your appointment.
A $50 fee may be charged for missed appointments or cancellations with insufficient notice.
Repeated missed appointments may result in dismissal from the practice.

Returned Payments
A fee of $25 will be charged for any returned checks or declined electronic payments.

Outstanding Balances
Statements are sent monthly. Balances over 30 days may accrue a monthly finance charge of 1.5% (18% annually).
Accounts over 90 days past due may be turned over to collections and subject to additional fees.

Treatment Plans & Estimates
We will present a treatment plan and cost estimate before performing any non-emergency procedures.
Estimates are based on information provided by your insurance company and are not a guarantee of coverage.
You have the right to decline or postpone treatment at any time.

Authorization
By signing below, I acknowledge that I have read, understand, and agree to the terms of this Financial Policy. I authorize Generations Dental Care to bill my insurance and understand I am financially responsible for all charges incurred.

PHOTOGRAPHY CONSENT AND USE FORM

I hereby give Generations Dental Care permission to take photographs and/or video recordings of me (or my child, if under 18) during visits, events, or treatment.
I understand that these images may be used for:
Marketing materials (flyers, brochures, signage)
Social media (Facebook, Instagram, etc.)
Website or blog content
In-office display
Educational or promotional purposes
I acknowledge that:
No personal identifying information (such as full names or contact info) will be shared unless I give explicit permission.
Images will not be sold to third parties.
I will not receive monetary compensation for the use of these photos.

_____ _____

Patient Signature **Date**