J. Brad Carr, D.M.D.

Authorization for treatment, release of dental information, and assignment of insurance benefits.

AUTHORIZATION TO RELEASE: I hereby authorize J. Brad Carr, D.M.D. to release or disclose to insurance companies or other benefit programs information from my dental record pertaining to my treatment as needed to process insurance claims.

AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby assign payment directly to J. Brad Carr benefits wherein specified and otherwise payable to me but not to exceed J. Brad Carr, DMD's regular charges for dental treatment. I understand that I am financially responsible for charges not covered by this authorization.

CONSENT FOR TREATMENT: The undersigned authorizes Dr. Carr to furnish dental treatment by those means he considers necessary and proper in the treatment of the patient identified below while a patient of his practice. This treatment may require diagnostic procedures.

VALUABLES: The undersigned hereby releases Dr. Brad Carr and his staff or employees from responsibility due to loss or damage of any valuables that the patient may keep in his/her possession or that may be brought to him/her by other persons.

_____

Patient Name **Date**

FINANCIAL AGREEMENT: I authorize Dr. J. Brad Carr to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

I understand that I am responsible for all services, due and payable by the dates agreed upon. I understand if my account becomes delinquent, I will be responsible for any additional charges incurred in the collection of my account.

Should the account be referred to an attorney or collection agency for collection, I, the undersigned shall pay actual attorney's fees and collection expenses, including the collection agency's fee, court cost and all expenses related to the cost of collecting the account.

In Addition, this agreement shall be governed by, and construed in accordance with the laws of the state where the assigned collection agency and /or attorney is located, exclusive of choice of law rules. The parties each hereby consent to the jurisdiction and venue and waive any objections to such jurisdiction and venue.

_____ _____ _____

Printed Patient Name **Patient Signature/Guardian if Minor** **Date**

J. Brad Carr, D.M.D.

Today's Date: _____

ABOUT YOU

NAME: _____
I prefer to be called: _____
Male_____Female_____Age_____
SS#_____
Date of Birth_____
Home Address_____
City_____ **State**_____
ZipCode_____
Single____Married_____Divorced_____Widow_____
Home#_____ Cell #_____
Wk#_____Ext_____
Email address_____
Who may we thank for referring you?
_____
Other immediate family members seen by us
_____
Previous Dentist_____
_____

EMPLOYER

Employer: _____
Occupation: _____

SPOUSE INFORMATION

Their Name_____
Employer_____
Wk#_____Cell #_____
SSN_____
Date of Birth_____
Email Address_____

PERSON RESPONSIBLE FOR ACCOUNT

Name_____
Work#_____EXT_____
Billing Address_____
_____
Relationship_____
SSN#_____
Employer_____
Date of Birth_____

PRIMARY DENTAL INSURANCE

Insurance Co. Name_____
Insurance Co. Address_____
_____
Ins. Phone #_____
Group #_____
Or Policy#_____
Insured's Name_____
Insured's Birthdate_____
Insured's SS#_____
Insured's Employer_____

IN THE EVENT OF AN EMERGENCY, IS THERE SOMEONE WHO LIVES NEAR YOU THAT WE SHOULD CONTACT?
Their Name_____
Relation_____
Wk#_____
Hm#_____

MEDICAL HISTORY

Do you have a personal physician?_____
Physician's Name_____
Last Visit_____
Your current Physical Health is:
Good_____Fair_____Poor_____
Are you currently under the care of a physician? _____
Please Explain_____
Are you taking any prescription or over the counter medications? _____
Please list Each One_____
_____
_____
Are you taking Birth Control Pills?_____
Are you pregnant or think you could be?_____

Do you smoke?_____
How much per day?_____How many years?____
Any other form of tobacco?_____
Type:_____ How much per day?_____
Do you drink alcoholic beverages?_____
How often?_____ Type:_____

Have you ever had any of the following diseases or medical problems?
(Please Circle)

Psychiatric Problems
Drug / Alcohol Abuse
Epilepsy/ Seizures / Fainting Spells
Stroke Sinus Problems
Frequent Headaches Facial Pain
Heart Attack Heart Murmur
Mitral Valve Prolapse Artificial Valves
High/Low Blood Pressure
Artificial Joints/ Pins / Screws
Asthma/ Breathing Difficulty
Tuberculosis Emphysema
Diabetes Ulcers Arthritis
Hepatitis A, B, C, or D
Blood Transfusion
Cancer Chemotherapy Radiation Therapy
Venereal Disease
HIV AIDS
Kidney Problems

Please list any other serious medical conditions that you have ever had:

_____

_____

Are you allergic to any of the following medicines?
Penicillin Aspirin
Dental Anesthetics Erythromycin
Tetracycline Codeine
Latex
Other_____

_____

Have you ever had an unfavorable reaction reaction Associated with dental work?_____
Explain_____
_____

I understand that the information that I have given today is to the best of my knowledge. I hereby grant J. Brad Carr, D.M.D. permission to administer any treatment; or to administer such anesthetic; and
to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of above patient after procedures have been fully explained to the patient, parent, or guardian and gaining approval. I understand that any balance over 60 days old will be subject to a 1.5% finance charge, and that insurance estimates are estimates only, and I am responsible for insurance claims not paid and all charges incurred.

_____
Signature Date

James B. Carr, DMD

ACKNOWLEDGEMENT OF RECEIPTS OF NOTICE OF PRIVACY PRACTICES

*** You May Refuse to Sign This Acknowledgement***

I, _____, have received a copy of this office's Notice of Privacy Practices.

Dr. James B. Carr has my permission to use my information for my treatment in this office, collecting payment of services from myself and insurance companies involved and referrals to other medical or dental providers as necessary to my treatment.

_____

(Please Print Name)

_____

(Signature)

_____

(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign
_____ Communications barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (Please Specify)

_____