David L. Walker, D.M.D.
Eric C. Raynal, D.M.D.
Family, Cosmetic, Restorative and Implant Reconstruction Dentistry

Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can care for you!

Name _____ PH# Home: _____
S.S. # _____ Work: _____

1 About You

Name _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate ___/___/___ Age: ____ SS#: _____
APT/CONDO #

Home Address: _____

_____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home #: _____ Pager / Other #: _____

WK #: _____ Ext. ____ DL#: _____

E-mail Address: _____

Employer: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Who may we thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(PLEASE CIRCLE)

Last Visit Date: _____

2 Spouse or Parent Information

Their Name: _____

Employer: _____

WK #: _____ Ext _____ SS#: _____

Birthdate _____ DL# _____

Person Responsible for Account: _____

WK# _____ Ext _____ HM#: _____

Billing Address _____
ZIP

Relationship: _____ SS#: _____

Employer: _____ DL# _____

3 Dental Insurance

Ins. Co. Name: _____

Ins Co. Address: _____

_____

Ins. Co. Phone #: _____

Insured's Name: _____

Group# _____ Relation: _____

Insured's Birthday _____ Insured's SS#: _____

Insured's Employer: _____

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my benefit plan, unless the treating dentist has a contractual agreement with my plan limiting a portion of such charges. To the extent permitted under applicable law, I authorize release of information relating to my dental claims.

_____
Signature Date

I hereby authorize payment of the dental benefits otherwise payable to me directly to the dental entity "Walker and Raynal, DMD's"

_____
Signature Date

Please provide a copy of your insurance cards(s) and Driver's License (or other photo ID)

In the event of an emergency, is there someone outside your household that we should contact?

Their Name _____ Relation: _____

WK #: _____ HM #: _____

Our office is committed to meeting or exceeding the stardards of infection control mandated by OSHA, the CDC and the ADA.

4 Medical History

Do you have a personal physician? ☐ No ☐ Yes

Physician's Name: _____

Phone # _____ Date of Last Visit: _____

Are you currently under the care of a physician? ☐ No ☐ Yes

Please Explain: _____

Are you taking any prescription/over-the-counter drugs?

Please list each one: _____

For Women Are you taking birth control pills? ☐ No ☐ Yes

Are you pregnant? ☐ No ☐ Yes Week _____

Are you nursing? ☐ No ☐ Yes

Have you ever had any of the following diseases or medical problems?

Y N Heart Attack / Stroke
Y N Cancer / Chemotherapy
Y N Heart Murmur
Y N Rheumatic Fever
Y N Pacemaker
Y N Heart Surgery
Y N Shingles
Y N Mitral Valve Prolapse
Y N Kidney Problems
Y N Artificial Bones / Joints
Y N Artificial Valves
Y N Sinus Problems
Y N High / Low Blood Pressure
Y N Fever Blisters
Y N Severe/Frequent Headaches
Y N HIV + / AIDS
Y N Psychiatric Problems
Y N Epilepsy/Seizures/Fainting/Spells
Y N Diabetes / Tuberculosis (TB)
Y N Drug / Alcohol Abuse
Y N Sexually Transmitted Diseases
Y N Hemophilia / Abnormal Bleeding
Y N Ulcers / Colitis
Y N Glaucoma
Y N Anemia
Y N Asthma / Difficulty Breathing
Y N Arthritis
Y N Hospitalized for Any Reason
Y N Hepatitis
Y N Blood Transfusion
Y N Emphysema
Y N Cochlear Implant

Please list any serious medical condition(s) that you have ever had

_____

_____

Are you allergic to any of the following drugs?

Y N Penicillin
Y N Aspirin
Y N Erythromycin
Y N Tetracycline
Y N Dental Anesthetics
Y N Codeine
Y N Latex
Y N Other

Please list any other drugs that you are allergic to

_____

_____

5 Dental History

Why have you come to the dentist today? _____

_____

Are you currently in pain? ☐ No ☐ Yes

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ No ☐ Yes

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ No ☐ Yes

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ No ☐ Yes

Do your gums ever bleed? ☐ No ☐ Yes

Do you smoke? ☐ No ☐ Yes

How many times a week do you floss? _____

Type of bristles? ☐ Hard ☐ Medium ☐ Soft

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence.
In consideration of professional services rendered or to be rendered, I agree to be financially responsible for all charges (at the Doctor's usual and customary fee) and for any expense which the Doctor may incur in collecting these fees, including ATTORNEYS' FEES.

_____
Signature Date

Payment is due in full at the time of treatment unless prior arrangements have been approved. Any balance over 60 days past due automatically accrues a finance charge of 18% APR.

_____
Doctor's Signature Date

_____
Witness Date

Dr's David Walker and Raynal D.M.D. P.A.
212 N. Moon Avenue
Brandon, FL 33510
813-689-5928

PAYMENT POLICIES

❖ **FIRST APPOINTMENT**

Full payment is required at the time services are rendered. We accept personal checks, cash, or credit cards (MasterCard, Visa, American Express and Discover). All extractions are to be paid in advance of treatment.

❖ **INSURANCE WELCOME**

If you carry dental insurance, we will need a copy of your insurance information. We will allow 45 days for your insurance company to pay. If there is a delay, we will work with your insurance company to resolve it for you. However, your balance will be due and we will instruct the insurance company to reimburse you. **We encourage all patients to be familiar with their own insurance policy, as many limitations and exclusions may exist that we will not be able to predict prior to treatment. We do not work with any HMO's or DMO's, you must have PPO out-of-network benefits.**

❖ **INTEREST FREE FINANCING**

Financing is available through. Carecredit. Your dental fees can be financed in six or twelve month payments. Carecredit also has a long term plan for those who need it. Interest will apply to long term plans. A loan application must be completed and approved before services are rendered.

Any balance past due by more than 60 days will automatically accrue a finance charge of 18% A.P.R. (1.5% per month)

❖ **CANCELLATION POLICY**

Broken appointments where a 24-hour notice is not given will be charged a $75.00 fee.

If you have any questions regarding the office policies, we encourage you to ask prior to treatment. We are always waiting to help you with a smile.

I hereby acknowledge that I have read and understand these policies.

_____

(Signature of Financially Responsible Party) **(Date)**

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212 N. Moon Avenue
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SECTION A: THE PATIENT

Name: _____

Address: _____

Telephone: _____ E-Mail: _____

Social Security: _____

SECTION B: ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I _____, acknowledge that I have read the Notice of Privacy Practices from the above named practice.

Signature: _____ Date: _____
(If a personal representative signs this authorization on behalf of the individual, complete the following).

Personal Representative Name: _____

Relationship to Individual: _____

SECTION: C: GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGEMENT OF RECIEPT

Describe the reason why the individual would not sign this form: _____

_____

SIGNATURE:
I attest the above information is correct:

Signature: _____ Date: _____

Print Name: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE