Christopher M. Herman D.D.S.

Patient Information

(This information is necessary for our files and will be considered confidential)

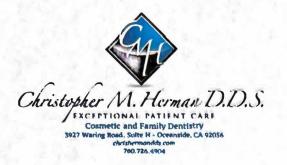
Today's Date						
Patient's Name		Date of Birth_	Age_	Age		
والساليف أيوا	MarriedSing	gleDivorcedSept	aratedWidowed			
	Student/Name of Sci	City/State				
If patient is	a minor, parent or g	guardian's name				
Home address		City	Zip			
Home phone #	E-mo	all address				
Cell phone #	phone # Drivers license#			State Social Security #		
Patient/parent employe	d by	Occupation				
Address			Business Phone#			
Spouse's name Date of Birth			Social Security #			
pouse employed by		Occupation				
Business address		Business phone#				
Name of nearest relative	e not living with you_	Relationship				
Address			Home phone #			
Name of Physician		City	Phone # _			
			Phone # _			
Whom may we thank for	r referring you to our	office	and the second second second			
		NSURANCE INFORMATION				
rimary insured's name_		Secondary insur	Secondary insured's name			
nsurance Co		Insurance Co _	Insurance Co			
Group/Policy#		Group/Policy#_	Group/Policy#			
mployer		Employer	Employer			

TERMS & CONDITIONS

As a condition of your treatment by this office, financial arrangements must be made in advance. All emergency services or dental services performed without financial arrangements must be paid for at the time of the visit. We will help prepare your insurance forms to assist in collection from your insurance and credit your account, however, this office cannot render services on the assumption that our charges will be paid by an insurance company. I grant you permission to telephone me at home or work to discuss matters related to this form. I have read and understand the above conditions.

HEALTH QUESTIONAIRE

Yes No Are you in good health? Are you under the care of a physician? If yes, what is the condition being treated? Have you ever had any serious illness or operation? If yes, what was the illness or operation?								
Do you require antibiotic pre-medication for dental treatment? If Yes, which medication? Do you have any disease or condition not listed that we should be aware of? If yes, please explain								
List Medications you are currently taking:			☐ Asp ☐ Per ☐ Cod	Allergies or sensitivities to: Aspirin Barbiturates(Sleeping Pils) Penicillin Local Anesthetic Codeine Tetracycline Iodine Sulfa Latex Other		Artificial Joints: Hip When? Knee When? Other When?		
Do you	u ha	ve, or have	you had, any of the	e followin	ng: (Please check l	known conditions)		
□ Angina □ Artificial Heart Valve □ Congenital Heart Lesions □ Heart Murmur When Diagnosed □ Heart Problems □ Mitral Valve Prolapse □ Pacemaker □ Phenymatic Fever		sease ser sease sspiratory sease berculosis enereal sease/	Other Conditions: Anemia Arthritis/ Rheumatism Asthma Back Problems Bleeding abnormally with extraction, surgery Cancer Type	Chemical Dependency Chemotherapy Circulatory Problems Contact Lenses Cortisone Treatments Cough, persistent or bloody Fainting/Dizziness Headaches High Blood Pressure	Treatment on Head/Neck			
Present User Former User For how long? For								
How long has it been since your last dental How do you feel about your teeth? Are you satisfied with the appearance of your				al treatm	treatment?Last		x-rays?	
Yes	≥00000	Does food Do your gr Have you Do you gr Do you ho Do you ho	itend to get caught ums often bleed who experienced proble ind or clench your te ave popping or sorer ave difficulty opening ave difficulty with che	betwee en you b ms with y eeth? ness in yo g or closii	en your teeth? orush? your jaw? our jaw?			
Have you ever had: Orthodontic treatmen			ent?	When? When?	Oral surgery? Worn a bite o	When?		
FOR WOMEN ONLY: Are you pregnant? E Are you taking birth o					ng? 🗆 Yes 🗆 No			
l herek	ру се	ertify that th	ne above information	n Is true c	and correct to best	of my knowledge	Э.	
Signature (Parent			it, if patie	ent is a minor)	Dai	e		



Insurance

If we have received all of your insurance information on the day of the appointment, we will be happy to file your claim for you. You must be familiar with your insurance benefits, as we will collect from you the estimated amount insurance is not expected to pay. By law your insurance company is required to

pay each claim within 30 days of receipt. We file all insurance electronically, so your insurance company will receive each claim within days of the treatment. You are responsible for any balance on your account after 30 days, whether insurance has paid or not. If you have not paid your balance within 60 days a re-billing fee of 1.5% will be added to your account each month until paid. We will be glad to send a refund to you if your insurance pays us.

PLEASE UNDERSTAND that we file dental insurance as a courtesy to our patients. We do not have a contract with your insurance company, only you do. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of treatment. We at no time guarantee what your insurance will or will not do with each claim. We also can not be responsible for any errors in filing your insurance. Once again, we file claims as a courtesy to you.

Dental Appointment Cancellation/No Show Policy

Thank you for trusting your dental care to Dr. Herman's Office. When you schedule an appointment with our office we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Please see our Appointment Cancellation/No Show Policy below:

Effective January 1, 2022 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours notice will be considered a No Show and charged a \$50.00 fee.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee.

Should it be after regular business hours Monday through Thursday, or a weekend, you may leave a message via phone or text. Messages left at either location are acceptable.

Dr. Christopher Herman DDS 760.726.4904 chrishermandds@gmail.com

Printed Name:	Date:
Signature:	그걸 맛있다. 그는 그렇게 된다
Relationship to Patient:	