David A. Page; D.D.S.

FAMILY DENTISTRY

*** Patient Information (Confidential)**

Name ____________ Birthdate ____________

Street Address ____________ Phone ____________

City ____________ State ________ Zip Code ____________

Social Security Number ____________

If College Student Name of School/College ____________

City ____________ State ____ Full Time __ Part Time __

*** Responsible Party**

Name of Person Responsible for this Account ____________

Relationship to Patient ____________

Address ____________ Home Phone ____________

Employer ____________ Work Phone ____________

*** Dental Insurance Information**

Name of Subscriber ____________

Relationship to Patient ____________ Birthdate ____________

Social Security # ____________

Name of Employer ____________ Work Phone ____________

Address ____________ City ____________ State ___ Zip ______

Insurance Company ____________ Group # ____________

Address ____________ City ____________ State ___ Zip ______

Do you have any additional Dental insurance? Yes No

Name of Subscriber ____________

Relationship to Patient ____________ Birthdate ____________

Social Security # ____________

Name of Employer ____________ Work Phone ____________

Address ____________ City ____________ State ___ Zip ______

Insurance Company ____________ Group # ____________

Address ____________ City ____________ State ___ Zip ______

Whom May We Thank For
Referring You To Our Office? ____________

Name and address of nearest relative not living with you to be contacted in case of necessity.

Name ____________ Phone ____________

Address ____________

Relationship ____________

I have received a Notice of Privacy Practices from River Falls Family Dentistry LTD.

I have read, understand and agree to the terms of the financial agreement on the back of this form.

Please do not sign this before you read the agreement on the back, even if you are advised otherwise.

Please ask for a copy of our financial agreement. You are entitled to an exact copy of any agreement you sign.

Signature ____________

Please indicate whether or not you have had any of the following conditions (check yes or no). Do not leave blank

	Yes	No
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Heart Attack	☐	☐
Stroke	☐	☐
Rheumatic Fever	☐	☐
Mitral Valve Prolapse	☐	☐
Any Other Heart Problem	☐	☐
Have You Ever Taken PhenFen or Redux	☐	☐
Bleeding Problems	☐	☐
Renal Dialysis	☐	☐
Diabetes	☐	☐
Anemia	☐	☐
Cancer	☐	☐
Radiation Treatment	☐	☐
Surgeries *(Year, Type)*	☐	☐
Tuberculosis	☐	☐
Lupus Erythematosis	☐	☐
Arthritis	☐	☐
Prosthetic Joint (Joint Replacement)	☐	☐
Other Implants	☐	☐
Venereal Disease	☐	☐
AIDS or HIV+	☐	☐
Other Immunosuppression	☐	☐
Asthma	☐	☐
Sinus Problems	☐	☐
Chemical Dependency	☐	☐
Latex Allergy	☐	☐
Drug Allergies	☐	☐
List any medications you are taking	☐	☐

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____

Are You Under A Physician's Care? ☐ ☐

Physician ____________

Phone Number ____________

Are You Pregnant? ☐ ☐

Are You Breast Feeding? ☐ ☐

Do You Smoke or Chew? ☐ ☐

How Much? ____________

The information I have provided here is complete and accurate to the best of my knowledge.

I understand that providing incorrect information can be dangerous to my (or the patient's) health. I hereby authorize Dr. Page to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

Date ____________

FINANCIAL AGREEMENT

1. I agree to pay the amount charged by Dr. Page for all professional treatment and services to the patient indicated on the front: payment to be made to David A. Page, D.D.S., 107 East Locust Street, River Falls, Wisconsin 54022.
2. I authorize Dr. Page to furnish to my dental or health insurance company all the information which said company may request concerning treatment for myself and or dependents.
3. I assign to Dr. Page the dental and/or medical - surgical benefits to which I or my dependents are entitled under my dental or health insurance. I understand that I am financially responsible for all charges.
4. I agree to make payment in full for all charges within 60 days of date of service unless a written financial agreement has been made in advance.
5. Sixty days after statement closing date(always a minimum of60days from date of service),1agree to pay Dr.Page a **FINANCE CHARGE** computed at the periodic rate in the State of Wisconsin of 1% per month (12% annually).
6. This **FINANCE CHARGE** will be applied to my adjusted balance-(previous balance after deducting current payments and/or credits appearing on my statement).
7. I can avoid incurring a **FINANCE CHARGE** by paying my account balance in full within 60 days of service provided that payment is received by Dr. Page before the next billing date. This allows for a minimum of 60 days from date of service to pay account without incurring a **FINANCE CHARGE.**

IN CASE OF BILLING ERRORS OR INQUIRIES ABOUT YOUR BILL

The Federal Truth in Lending Act requires prompt correction of billing mistakes.

I. If you want to preserve your rights under the Act, here's what to do if you think your bill is wrong or you need more information about an item on your bill.

A. Do not write on the bill. On a separate sheet of paper write the following: (You may also telephone your inquiry, **but doing so will not preserve your rights under this law.)**

1. **Your name.**
2. **A description of the error and an explanation (to the extent you can explain) why you believe it is an error. If you only need more information, explain the item you are not sure about and, if you wish, ask for evidence of the charge. Do not send in your copy of any document relating to that charge unless you have a duplicate copy for your records.**
3. **The dollar amount of the suspected error.**
4. **Any other information (such as your address) which you think will help us identify you or the reason for your complaint or inquiry.**

B. Send your billing error notice to: David A. Page, D.D.S., 107 East Locust Street, River Falls, Wisconsin 54022.

II. We must acknowledge all letters pointing out possible errors within 30days of receipt,unless we are able to correct your bill during that 30day period. Within 90 days after receiving your letter, we must either correct the error or explain why we believe the bill was correct. Once we have explained the bill, we have no further obligation to you even though you still believe there is an error, except as explained in the Paragraph V below.

III. After we have been notified, neither we nor an attorney nor a collection agency may send you collection letters or take other collection action with respect to the amount in dispute; but periodic statements may be sent to you, and the disputed amount can be included in determining your present account balance. You cannot be threatened with damage to your credit rating or sued for the amount in question, nor can the disputed amount be reported to a credit bureau or to other creditors as delinquent until we have answered your inquiry. **However, you remain obligated to pay that portion of your bill which is not in dispute.**

IV. If it is determined that we have made a mistake on your bill, you will not have to pay any finance charges on any disputed amount. If it turns out that we have not made an error, you may have to pay finance charges on the amount in dispute, and you will have to make up any missed minimum or required payments on the disputed amount. Unless you have agreed that your bill was correct, we must send you a written notification of what you owe; and if it is determined that we did make a mistake in billing the disputed amount, you must be given the time to pay which you normally are given to pay undisputed amounts before any more finance charges or late payment charges on the disputed amount can be charged to you.

V. If the explanation given by us does not satisfy you and you notify us in writing within ten days after you receive its explanation that you still refuse to pay the disputed amount, we may report you to credit bureaus and other creditors and may pursue regular collection procedures. But we must also report that you think you do not owe the money, and we must let you know to whom such reports were made. Once the matter has been settled between you and us, the resolution of the matter must be reported by us to all parties to whom it had originally reported you as delinquent.

VI. If we do not follow these rules, we are not allowed to collect the first $50.00 of the disputed amount and finance charges, even if the bill turns out to be correct.

** The Federal Equal Credit Opportunity Act prohibits from discriminating against applicants on the basis of sex or marital status. The Federal agency which administers compliance with this law concerning this dentist is the Federal Trade Commission, 55 East Monroe Street, Chicago, Illinois 60603.