WINCHESTER FAMILY DENTISTRY, P.C.
JAMES R. WINCHESTER, D.D.S.
5815 MOON ROAD
TELEPHONE (706) 563-6027 COLUMBUS, GEORGIA 31909

DATE____/____/____

Mr. Mrs. Ms. Dr.

Name _____ SS# _____

Address _____
Street Apartment # City State Zip Code

Home Phone _____ Cell Phone _____ E-mail Address _____

DOB _____ Age _____ ☐ Male ☐ Female Child's School _____

Employer Name _____ Business Phone _____

Address _____
Street City State Zip Code

Name of Spouse or Parent _____ Business Phone _____

Address _____
Street Apartment # City State Zip Code

Employer Name _____ Address _____

Name of Responsible Party _____ Relationship to Patient _____

PRIMARY INSURANCE _____ SECONDARY INSURANCE _____

Name of Insured _____ Name of Insured _____

Insured SS# _____ DOB _____ Insured SS# _____ DOB _____

Other family members who are patients? _____

MEDICAL HISTORY

Are you allergic to any medicines or drugs? Yes ☐ No ☐
Please list _____

Do you take a blood thinner? Yes ☐ No ☐
Please list _____

Are you under the care of a physician now? Yes ☐ No ☐
Please list condition _____

Have you had any joint replacements? Yes ☐ No ☐
Have you ever taken Fosamax or Boniva? Yes ☐ No ☐
Do you smoke or use tobacco products? Yes ☐ No ☐
(Female) are you pregnant? Yes ☐ No ☐

List any medicine you are taking:

Please check any that apply.

__ Heart Disease/Heart Attack
__ Heart Pacemaker/Heart Surgery
__ Heart Murmur
__ Mitral Valve Prolapse
__ Required to PreMed for Dental Procedures due to Heart Murmur/MVP/ Artificial Joint
__ AIDS
__ Allergies
__ Arthritis
__ Asthma
__ Cancer
__ Diabetes
__ Epilepsy/Seizures
__ Excessive Bleeding
__ Hepatitis – Type: A B C
__ High Blood Pressure
__ Kidney Disease
__ Fainting
__ Liver disease
__ Rheumatic Fever
__ Emphysema
__ Stroke
__ Tuberculosis
__ Other

In Case of Emergency-	Name _____	Telephone _____
Who should we contact? (Other than person named on reverse).	Address _____	Work Phone _____
	City _____ State ____	Relationship _____
Who Referred You to Our Office?		

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF INSURANCE BENEFITS

I understand that the charges of this account remain the responsibility of the person signing this form, either: the Patient, Guarantor, Parent, Guardian or accompanying adult.

I understand that my appointment time has been reserved just for me. If it becomes necessary to reschedule or cancel an appointment, a 24-hour advance notice is required. Failure to give our office this advance notice may result in a $35 Broken Appointment Fee.

* As a service to you and/or your family, our office, Winchester Family Dentistry, P.C. will file your Dental Insurance Benefits. However, please remember that Insurance is NOT a guarantee of payment and is not to be considered as a total method of payment for our services. The Patient/Guarantor is responsible to pay any deductibles or patient estimated portions at the time of service.

* If for any reason the Insurance Company does not pay, I (the undersigned) assume **full responsibility** of the unpaid charges. If the Insurance Company does not pay benefits within **60 days** from our filing date, the Guarantor will become responsible for the outstanding balance.

* PRICES, FEES OR BENEFITS QUOTED IN OUR OFFICE ARE ESTIMATES ONLY. FINAL CHARGES OR BENEFITS PAID BY THE INSURANCE COMPANY WILL BE BASED ON WORK PERFORMED AND CLAIMS FILED AFTER WORK HAS BEEN COMPLETED.

I understand that if a check I have written for dental treatment is returned by the bank for non sufficient funds there will be a Returned Check Fee of $30.

I understand that unpaid balances may be subject to 1.50% (APR 18.00%) Monthly Finance Charge.

If this account becomes past due and is assigned to an attorney or collection agent, Winchester Family Dentistry, P.C. is entitled to all reasonable attorney's fees and/or costs of collection.

The undersigned agrees, whether signed as Agent, Guarantor, or Patient, that in consideration of the services to be rendered to the Patient, the patient hereby individually obligates himself to pay the amount of the account to this office in full at the time services are rendered. Further, should it become necessary to enforce collection of the account, the undersigned(s) singularly and jointly agrees to all such collection expense. All delinquent accounts bear interest charges at the highest legal rate. Further, the undersigned(s) agree to pay 15% attorney fees if the account is collected by or through an attorney at law.

* I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement of any insurance claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled to Winchester Family Dentistry, P.C. This Assignment will remain in effect until revoked by me in writing. A photocopy of this Assignment is to be considered as valid as an original.

I fully agree to the Financial Responsibilities and Assignment of Insurance Benefits* as stated above.

YOU SHOULD READ THESE TERMS CAREFULLY.

X _____ _____ _____

Signature Printed Name Date

* If you do not have Dental insurance and we are not filing for your benefits, these statements will not apply to your account.