## Health History Update

Patient Name: ______________________________

Medical Alerts: ______________________________

Notes: ______________________________

| DATE: | HEALTH UPDATE | DATE: | HEALTH UPDATE |
|---|---|---|---|
| B/P | Signature | B/P | Signature |
| DATE: | HEALTH UPDATE | DATE: | HEALTH UPDATE |
| B/P | Signature | B/P | Signature |
| DATE: | HEALTH UPDATE | DATE: | HEALTH UPDATE |
| B/P | Signature | B/P | Signature |
| DATE: | HEALTH UPDATE | DATE: | HEALTH UPDATE |
| B/P | Signature | B/P | Signature |

# *Hillcrest Family Dental Center, P.C.*

## *Acknowledgment and Authority*

### For All Patients

I understand that there can not be guarantees of any services rendered when dealing with the human body. I also understand that periodic visits are necessary and my responsibility to help maintain good oral health. I am aware that services rendered by John P. Ahler, D.D.S. and Jack W. Drone, DD.S., are dental in nature and as such are not covered by Medicare. I also give my consent to Hillcrest Family Dental Center, P.C. to contact me regarding my dental health, periodic recall, appointment scheduling, personal and/or account information by telephone, email, postcard, newsletter and/or letter.

I understand that any and all records, clinical data, appliances, models, radiographs, videotapes and photographs taken before, during, and after examination and treatment shall remain the property of John P. Ahler/Jack W. Drone/Hillcrest Family Dental Center P.C.

### Acknowledgement and Authority

I consent to treatment as necessary or desirable for the patient named, including but not restricted to drugs, medicine, performance of operations & conduct of laboratory, x-ray, or other studies that may be used by the attending Doctor, staff or qualified designate. I hereby provide authorization to Hillcrest Family Dental Center, P.C. to release information contained in this record needed for substantiation of this or a related claim to third party &/or healthcare practitioners. I authorize & request my insurance company to pay Hillcrest Family Dental Center, P.C. directly, otherwise payable to me. **I understand my insurance carrier may pay less than my total bill for services rendered & unconditionally agree to be responsible for, and to pay all charges incurred on my behalf or my dependents.** I permit a copy of this authorization to be used in place of the original. In consideration of the services to be provided to the patient, I/we hereby guarantee payment in full of the patient's account in accordance with the financial arrangements made at the time of discharge or if no such arrangements are made, then payment shall be made in full within thirty (30) days of discharge. I (we) agree to pay trebel damages if I (we) cash any dental insurance checks that represent reimbursement for the Doctor's charges and I (we) fail to tender monies to Hillcrest Family Dental Center, P.C. I/we that in the event of default in payment, reasonable collection agency fees, reasonable attorney fees & incidental expenses shall be added to the amount due on the account, plus any applicable court costs. I further understand a 1.5% finance charge per month (18% annually) will be added to my account for any balance over 60 days, regardless of pending insurance claims. The information I have given today is correct to the best of knowledge. I also understand my personal information will be held in confidence in accordance with HIPAA standards, and it is my responsibility to inform Hillcrest Family Dental Center, P.C. of any changes in my personal and/or medical status. I authorize Hillcrest Family Dental Center, P.C. or qualified designate to perform dental services that I may need during diagnosis and treatment with my informed consent. If the patient is a minor, I certify I am the legal guardian and consent to treatment on their behalf. If parents of a child/minor are divorced, the parent bringing the child for care is responsible for payment of any and all charges. I (We) agree that Indiana law governs all matters arising out of this agreement and I (we) consent to the jurisdiction of the Jasper Superior Court I, Rensselaer, Indiana.

Patient Name ______________________________ Date ______________

Signed ______________________________ Date ______________

My signature confirms I am legally the Responsible Party, Parent &/or Authorized Guardian for the Patient named above.