Michael W. Uss, D.D.S.
1024 Main Street, Onalaska, WI 54650

Consent for Service

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid at the time services are performed. We do accept Cash, Checks, and major Credit Cards.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. This dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 ½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are established.

In consideration for the professional services rendered , by the Michael W. Uss, D.D.S., I agree to pay the reasonable value of said services to Michael W. Uss, D.D.S., or his assignee, at the time said services are rendered, or within five (5) days of billing after insurance payments are made. I further agree that a waiver of any breach of time or conditions hereunder shall not constitute a waiver of any further term or condition and agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this account.

I authorize Michael W. Uss, D.D.S., or assignee, to act as my agent in helping me to obtain payment from my insurance company(ies). I authorize Michael W. Uss, D.D.S. to initiate a complaint in my behalf if payment is not rendered 30 days after claim filing.

_____Date_____
Signature of Patient, Parent or Guardian

_____Date_____
Signature of Guarantor of Payment/Responsible Party

Patient Information

Patient Name:_____Date_____
Last Name First Name MI (Preferred Name)
Gender: _____ Family Status: (M, S, D, Child) _____ Birth Date: _____
Social Security #:_____-_____-_____ Home Phone:_____Work:_____
Address:_____
Cell Phone:_____ E Mail Address:_____
Physician's Name: _____ Physician's Phone : _____
Nearest Relative Not living with you:_____

Responsible Party Information

Name:_____Male___Female___
Relationship to the Patient: _____
Social Security #:_____-_____-_____Birth Date_____E-Mail Address_____
Home Phone: _____Work Phone: _____Best time to call _____
Address: _____

Employment Information

The Following is for: **O** The Patient **O** The person responsible for payment
Employer Name _____Occupation _____
Address: _____
Street City State Zip code Phone

Insurance Information

Name of Insured: _____Is Insured a Patient:_____
Insured's Birth Date_____ ID#_____ Group # _____
Insured's Address:_____
Street City State Zip Code
Patient's relationship to Insured: **O** Self **O** Spouse **O** Child **O** Other:_____
Insurance Plan Name and Address: _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

O Yes O No Are you under a physician's care now? If yes, please explain:_____
O Yes O No Have there been any changes in your health in the last year? _____
O Yes O No Have you ever been hospitalized or had a major operation? If yes, please explain:
_____
O Yes O No Do you use tobacco? IF Yes, What Kind and How Often? _____
O Yes O No Do you consume alcohol? How often? _____
O Yes O No Have you ever has to be pre-medicated prior to dental treatment?
O Yes O No Do you use controlled substances?

Women: Are you
Pregnant/Trying to get pregnant? **O** Yes **O** No Taking Oral Contraceptives? **O** Yes **O** No Nursing? **O** Yes **O** No

Are you allergic to any of the following?
□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Local Anesthetics
□ Other If yes, please explain: _____

Do you have, or have you had any of the following?

1. O Yes O No AIDS/HIV Positive
2. O Yes O No Anemia
3. O Yes O No Angina
4. O Yes O No Arthritis/Gout
5. O Yes O No Artificial Heart Valve
6. O Yes O No Artificial Joint
7. O Yes O No Asthma
8. O Yes O No Blood Disease
9. O Yes O No Breathing Problem
10. O Yes O No Bruise Easily
11. O Yes O No Cancer
12. O Yes O No Chemotherapy
13. O Yes O No Chest Pains
14. O Yes O No Cold Sores/Fever Blisters
15. O Yes O No Congenital Heart Disorder
16. O Yes O No Convulsions
17. O Yes O No Diabetes
18. O Yes O No Epilepsy or Seizures
19. O Yes O No Excessive Bleeding
20. O Yes O No Excessive Thirst
21. O Yes O No Fainting Spells/Dizziness
22. O Yes O No Frequent Cough
23. O Yes O No Frequent Headaches
24. O Yes O No Genital Herpes
25. O Yes O No Glaucoma
26. O Yes O No Hay Fever
27. O Yes O No Heart Attack/Failure
28. O Yes O No Heart Murmur
29. O Yes O No Heart Pace Maker
30. O Yes O No Heart Trouble/Disease
31. O Yes O No Hepatitis A
32. O Yes O No Hepatitis B or C
33. O Yes O No Herpes
34. O Yes O No High Blood Pressure
35. O Yes O No Hives or Rash
36. O Yes O No Hypoglycemia
37. O Yes O No Irregular Heartbeat
38. O Yes O No Kidney Problems
39. O Yes O No Leukemia
40. O Yes O No Liver Disease
41. O Yes O No Low Blood Pressure
42. O Yes O No Lung Disease
43. O Yes O No Pain in Joints
44. O Yes O No Psychiatric Care
45. O Yes O No Radiation Treatments
46. O Yes O No Recent Weight Loss
47. O Yes O No Renal Dialysis
48. O Yes O No Rheumatic Fever
49. O Yes O No Sinus Trouble
50. O Yes O No Stroke
51. O Yes O No Thyroid Disease
52. O Yes O No Tuberculosis
53. O Yes O No Tumors or Growths
54. O Yes O No Ulcers
55. O Yes O No Venereal Disease

Please List All Medications Prescription and over-the-counter:
_____
_____

Have you ever had any serious illness not listed above? O Yes O No If yes, please explain:
_____
_____