Chart No. _______ **PATIENT INFORMATION** License No. ________________ Admin. _____ Clinical _____

PATIENT INFORMATION

PLEASE PRINT! Circle: Married, Single, Divorced, Minor Best Appt. Time: Anytime, Morning, Afternoon, Evening, Saturdays Email ____________

Name ______________________________ Nick Name ____________ Title: Mr., Mrs., Dr., Ms.Home # ( ) ____________
Last First Middle

Work # ( ) ____________ Cell # ( ) ____________ Home Address ______________________________
Street City State Zip

Sex: M or F SS # ____________ Birthdate ____________ Age ______ Spouse/Parent ____________

Person Responsible for Payment ______________________ Address ______________________________
Last First Middle Street City

____________ Home # ( ) ____________ Work # ( ) ____________ SS # ____________ Birthdate ____________ Age ____
State Zip

Sex: M or FEmployed by ____________ Work Address ______________________________
Street City State Zip

Dental Insurance ____________ Ins. Address ______________________________
Street City State Zip

Group # ____________ Ins. Phone # ( ) ____________ **WHO REFERRED YOU TO US?** ____________

Secondary **Dental** Insurance

Insured Name ____________ Birthdate ____________

SS # ____________ Ins. Co. ____________

Ins. Address ______________________________

Group # ____________ Ins. Phone # ( ) ____________

Medical Insurance

Insured Name ____________ Birthdate ____________

SS # ____________ Ins. Co. ____________

Ins. Address ______________________________

Group # ____________ Ins. Phone # ( ) ____________

CONFIDENTIAL MEDICAL HISTORY. Please circle those conditions that pertain to you:

Rheumatic Fever	High Blood Pressure	Stroke	Drug Addiction	Allergy to Metal	Hemophilia
Heart Murmur	X-ray/Cobalt Treatment	Ulcers	Psychiatric Treatment	Abnormal Bleeding	Scarlet Fever
Heart Disease	Hepatitis A-Infection	Cancer	Venereal Disease	Allergy/Hives	Fever Blister
Heart Transplant	Hepatitis B-Serum	Diabetes	Sickle Cell Anemia	Asthma/Hay fever	Bruises Easily
Heart Pacemaker	Hepatitis, Others	Arthritis	Thyroid Disease	Sinus Trouble	Alcoholism
Heart Surgery	Endocrine Problems	Liver Disease	Blood Transfusion	Cortisone Medicine	Tuberculosis
Artificial Implants	Faint/Dizzy Spells	HIV/AIDS	Epilepsy/Seizure	Yellow Jaundice	Rheumatism
				Chemotherapy	Pregnant

Others not listed ______________________ Blood Relatives with above Conditions ____________

If recently hospitalized, Reason ______________________ Medications currently taking ____________

Allergic to: Local Anesthetic, Latex, Darvon, Nitrous Oxide, Percodan, Codeine, Valium, Erythromycin, Penicillin, Others ____________

____________ Physician's Name ____________ City/State ____________ Phone # ( ) ____________

DENTAL HISTORY

	Yes	No
Do your gums bleed easily?	☐	☐
Do any of your teeth hurt?	☐	☐
Wear dentures/partials?	☐	☐
Do you grind or clench your teeth?	☐	☐
Does your jaw pop or click?	☐	☐
Do you get frequent headaches?	☐	☐
Injury to your mouth/face?	☐	☐
Does food get between any teeth?	☐	☐
Unhappy with your teeth?	☐	☐

Do you have pending treatment that has not been completed? ______________________________

List specialists already seen: Gum Specialist, Orthodontist, Oral Surgeon, Others ____________

Date of last dental visit and reason for last visit ______________________ Date of last X-ray of entire mouth ____________

Former Dentist Name ____________ Address ____________ Phone # ( ) ____________

Reason for leaving former dentist ____________ How can we help you? ____________

OFFICE POLICY REGARDING EMERGENCIES, CANCELLATIONS & PAYMENT OF FEES

1. **A $15.00/every 15 minute increments will be charged if you do not show up for your appointment unless 24 hour advanced notice is given.**
2. **Payment is required when service is rendered.**
3. For treatment over $2,500.00, a 10% discount is allowed if cash is paid for the entire amount in advance.
4. Insurance policy. We will aid you in the filing of your dental claim. **It is your responsibility to understand your insurance. We will not be responsible for any discrepancies between you and your insurance companies. You will ultimately be responsible for any payments due us.** Non-payment of your deductibles and co-payments constitutes fraud and is illegal.

Patient's Signature (Parent's) ______________________________ Date: ____________

THANK YOU FOR COMING TO OUR OFFICE

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NOTICE OF PRIVACY PRACTICES AKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1) Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2) Obtain payment from third-party payers (i.e., your dental and/or medical insurance).
3) Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have read your Notice of Privacy Practices posted in front of the reception desk containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _______________________________________ Relation to Patient: ________________________

Signature (Head of Household): ___________________________________ Date:______________________

HIPAA PRIVACY FORM

ACKNOWLEDGEMENT OF RECEPT OF NOTICE OF PRIVACY PRACTICES
You, As the Patient, May Refuse to Sign This Acknowledgement

I have read a copy of this office's Notice of Privacy Practice. Copy is posted or upon request a copy handed to be read. As adult of the household, I am signing this acknowledgement for the entire household.

Name (Head of Household): ____

Signature (Head of Household): ___________________________________ Date:______________________

For Office Use Only

A staff member attempted to obtain the patient's signature in acknowledgement on this Notice Of Privacy Practices Acknowledgement but was unable to do so as documented below:

- Communication barriers prohibited obtaining the acknowledgement.
- An emergency situation prevented us from obtaining acknowledgement.
- Other ____

FINANCIAL POLICY
Thank you for choosing us as your dental health care provider. We are committed to giving you exceptional dental treatment. The goal is not to allow the cost of treatment to prevent you from getting the quality care you need or desire. Our financial options are as follows and payment is due at time of service unless prior arrangements have been made:

1, Cash or Check ($40 returned check charge)
2, MasterCard, VISA, or Discover
3. Care Credit and Citi for patients desiring more than 90 days to pay for treatment
5% Discount for payment in full by cash prior to treatment for services exceeding $2,500.

Insurances
We are happy to submit the claims necessary to see that you receive the full benefits of your coverage; however we cannot guarantee any estimated coverage. Because the insurance policy is an agreement between you and the insurance company, we ask that all patients be directly responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits of your policy by electronically filing your claim the day of your appointment. If there are any complications, we will assist you with any information you may need. If you are unable to present a valid member identification card from your insurance carrier at your initial visit, we will expect payment in full until you are able to verify your insurance coverage. Payment for dental services is the responsibility of the patient.

Balances
The office cannot carry balances longer than 60 days, even if insurance payments are still pending. If your insurance company does not pay within 60 days, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you. If payment has not been received after 90 days, we will inform you of the delinquent account and if no action is taken to clear the account, this office will be required to employ a collection service to collect payment. The responsible party agrees to pay any fees associated with the collection of the account.

Missed Appointments
An appointment is a dedicated time set aside for you. When an appointment is broken or cancelled on short notice (less than 48hrs) it prevents us from helping someone else. Please provide at least a 48 Hour notice to change your appointment. A $15/every 15 minute increment will be charged if you do not show up for your appointment unless a 48 hour notice is given.

Usual and Customary Rates
In our office, we strive to maximize your insurance benefits and make any remaining balance easily affordable. Our fees are based on the quality materials we use and the time, effort and skill required in performing your needed treatment. We charge what is the usual and customary for our area. We will assist you with your benefit eligibility before treatment to help you calculate your estimated costs. We will be sensitive to your financial circumstances and do everything possible to help you achieve oral health. The patient is ultimately responsible for payment regardless of the insurance company's determination of usual and customary rates.

Waiver of Confidentiality
The patient understands if the office submits your account to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit report agency, the fact that you received treatment at our office may become a matter of public record.

Divorce Situations
The parent who brings the minor and has signed the financial agreement is responsible to pay for the child’s services independent of what a divorce decree may state. We are unable to bill separate parties; therefore parents can work out these details.

Finance Charge
A 1.5% finance charge will be billed for balances over 60 days.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. Most often, financial misunderstandings can be managed with a phone call. Please feel free to contact our wonderful staff at any time to discuss any concerns you may have.

By signing below, I agree and understand the Financial Policy.

Printed Name of Responsible Party ____

Name of Minor (if applicable)____

Signature of Patient or Responsible Party: ____

Date:____________________