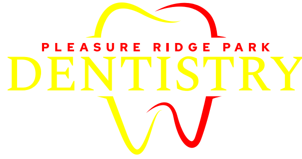


PATIENT INFORMATION FORM

Date: ____________________ How did you hear about our office? :_____________________________

Patient Information

Name: ________________________ Nickname: _____________ Gender: ______ Marital Status: _________________

Date of Birth: _________________ Age: _______ SS#: ____________________

Address: ___________________________ City: ________________ State: ____________ Zip Code: ______________

Home Phone: ___________________ Work Phone: ____________________ Cell Phone: ______________________

Email Address: _____________________________________ Driver's License #: ________________________________

Emergency Contact Information

Name: _______________________________ Relationship: _______________ Phone Number: ___________________

Responsible Party Information (If the party responsible is other than patient, that person needs to be present to sign below. The parent or guardian who brings in a minor is considered the party responsible unless legal documentation is presented to our office.

Name: ___________________________________ Date of Birth: __________________ SS#: _____________________

Address: ___________________________ City: _______________________ State: _________ Zip Code: __________

Phone Number: ____________________ Driver's License #: ____

Signature Agreeing to Financial Responsibility: _________________________________ Date: ____________________

Primary Dental Insurance Information

Insurance Company: ______________________________ Phone Number: _____________________________________

Person Who Carries Policy: ____ Date of Birth: _____________________

Member ID #: ___________________________________ Group #: ____

**PLEASE PRESENT INSURANCE CARD AT CHECK-IN FOR APPOINTMENT

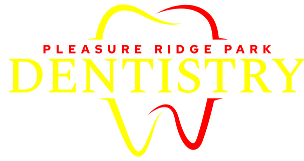
Secondary Dental Insurance Information

Insurance Company: ______________________________ Phone Number: _____________________________________

Person Who Carries Policy: ____ Date of Birth: _____________________

Member ID #: ___________________________________ Group #: ____

**PLEASE PRESENT INSURANCE CARD AT CHECK-IN FOR APPOINTMENT



GENERAL CONSENT

1. During the course, of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, oral pathology, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with doses, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I will pay in full any cost of treatment or insurance copayments and deductibles according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been pre-approved, I am responsible for any costs that my insurance does not cover.

5. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

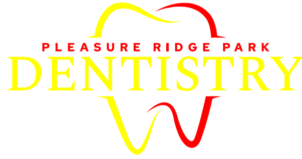
I give consent for myself or dependant to receive dental care including radiographic and clinical examinations. I also understand and consent to the above-listed statements.

Patient Name: ____

Signature of Patient: ____

Signature of Parent or Guardian: ____

Date: ____



NOTIFICATION AND AUTHORIZATION FOR USE OF IDENTIFYING HEALTH INFORMATION

Patient Name: ______________________________________ Date of Birth: __________________________________

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature, that you have reviewed our notice before signing this consent.

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Your insurance company(s), third-party payors, other healthcare providers and people you indicate have access to your appointment, account, or clinical treatment information.
2. The purpose of the release is at the request of the individual.
3. There is no expiration date for this authorization unless specifically requested by the patient.

It is completely your decision whether to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. If you are covered by a dental insurance plan, you will be required to file your own insurance claims as this office will not be able to release any information to them.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state, or federal law changes this.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient or Guardian Signature: ____ Date: _________________

If there is anyone you would like to have access to your account, appointment, or health information, please list their names and relationship below. This does apply to spouses and adult children.

Name: ____Relationship: _____________________________

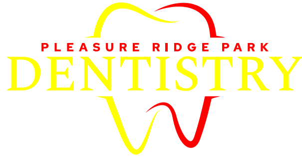
Name: ____ Relationship: _____________________________

Name: ____Relationship: _____________________________

Name: ____ Relationship: _____________________________

I DECLINE TO SIGN THIS FORM:

Signature: ____ Date: ____



FINANCIAL & APPOINTMENT POLICIES

FINANCIAL POLICY AND AGREEMENT: Payment is expected at the time services are rendered. Our patients who have dental insurance are expected to pay their estimated copay and deductible at the time of service. Payments may be made using cash, check, Visa, MasterCard or Discover. We also offer CARECREDIT, which is a financing option/ extended payment plan that is available only for healthcare expenses. We will mail monthly statements to all patients with an outstanding balance.

By arrangements with CARECREDIT we can offer patients upon approval an interest-free term loan (up to 12 months) with no down payment, no annual fee, and no prepayment penalty. Ask for an application. *Subject to terms and conditions, inquire at the office for details and exclusions.

As a courtesy to our insured patients, we submit claims to your insurance company free of charge. We will help you to receive your maximum allowable benefits. To do this, we need your insurance card and/or insurance policy with you on your first visit of every insurance calendar year (your insurance year may not run January – December). Please understand that insurance is a contract between the patient and the insurance company. If a claim is denied or not paid in full, it is the patient's responsibility for the total balance due to the dental practice. We cannot guarantee any estimate given by our dental practice. Our doctors will diagnose treatment based on your dental health **NOT** your insurance coverage.

Treatment Plans: Also, as a courtesy to our patients, we will generate treatment plans stating the treatment recommended by the Doctors and the fee(s) associated with the treatment. If you have dental insurance, we will include an estimate of how much your insurance is estimated to pay based upon the information they provide us.

The estimated portion not covered by your insurance will be due at the time of service. Please remember that we will strive to make this treatment plan as accurate as possible, however, this is only an estimate and the portion covered by your insurance may be more or less than quoted. There may also be rare instances in which your insurance will not cover any portion of the recommended treatment. In this situation it will be the patient's responsibility to pay the associated treatment fees.

APPOINTMENT POLICY AND AGREEMENT

To serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. We require at least 48 hours notice for any canceled appointment. Any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 48-hour notice will be considered a No Show and charged a $25.00 fee. Any established patient who fails to show or cancels/reschedules an appointment without 48-hour notice a second time will be charged a $50.00 fee. If a third, No Show or cancellation/reschedule without 48-hour notice should occur the patient may be dismissed from the practice. The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit. We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. This will be taken into consideration if or when it happens.

Please indicate your understanding and acceptance of these financial and appointment policies by signing below. It is understood that this executed copy of the Financial Policy also shall cover your dependent children (who are full-time students under the age of 25) who are patients of the practice.

Patient's name (please print): ____

Patient's Signature: ______________________________ Date: ____________________

Or Responsible Party's Signature: ______________________ Date: ____________________