I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name : _____

Signature of Patient: _____
(or guardian if minor)

Relationship to Patient: _____

Date Signed: _____

PATIENT/INSURANCE INFORMATION SHEET

Patient Information:

Name _____
Last First Middle Preferred Name

SS#: _____-_____-_____ Date of Birth: _____/_____/_____ Sex: Male/Female

Mailing Address: _____
Street City State Zip

Billing Address: _____
if different from above: Street City State Zip

Home Phone: _____ Work Phone:_____ Cell/Alternate_____
Email: _____

PRIMARY Insurance Information:

Subscriber's Name: _____ Relationship to Patient_____

Subscribers SS#: _____-_____-_____ Date of Birth: _____/_____/_____

Employer: _____

Insurance Company: _____ Plan/Group #: _____

Subscriber / Patient ID# If Applicable: _____

Insurance Phone#: _____

Additional Insurance Information:

Subscriber's Name: _____ Relationship to Patient_____

Subscribers SS#: _____-_____-_____ Date of Birth: _____/_____/_____

Employer: _____

Insurance Company: _____ Group #: _____

Insurance Phone#: _____

In an effort to better serve our patients, this office has adopted a policy of charging patients a missed appointment fee of $30.00 for all missed appointments UNLESS we receive 24 hour cancellation notice.

Signed:_____ Date:_____

FINANCIAL POLICY

- Our goal is to provide you with treatment that achieves and maintains optimal dental health. In order to help preserve this goal, we do ask that ***all fees not covered by insurance be paid at the time of service.*** Our staff will do their best to estimate this amount, and if a balance remains after insurance pays you will be billed.
- A 15 % discount is provided for uninsured patients.
- As part of our treatment goal we do not want you to put off necessary dental treatment, and for this reason we offer ***flexible no interest payment plans***. These arrangements must be made prior to treatment.
- Payments accepted are Personal Check, Cash, VISA, MasterCard, or Discover. As a convenience to you, payments by credit/debit card can be processed via phone. *A $30 charge will be added for returned or stopped checks.*
- All patients, or their parent/guardian if under 18 years of age, are personally responsible for the fees which they incur, regardless of any insurance coverage which may apply. In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.
- Interest of 1½% per month will be added to the account balance if the account goes 30 days past due after the insurance has paid.
- If your account has not been paid in full within 90 days, or as agreed to, it will be turned over to a collection agency, $30 will be added as a collection fee.

If you are covered under a dental insurance policy, please read the following:

- Your insurance policy is a contract between you and your insurance company. We are not party to that contract. However, it is our pleasure to assist you in maximizing your insurance benefits by completing and submitting claim forms to your insurance company. We do ask that you be as familiar as possible with your own dental plan and be responsible for monitoring all benefits and carrier payments pertaining to your annual maximum dental benefit. We realize that dental insurance can be quite overwhelming and confusing, and we will do our best to estimate insurance benefits upon your request. Please understand that it is only an estimate based upon information available to us at that time and **you are ultimately responsible for any and all amounts not paid by your insurance**. At this time we do not process claims to secondary insurance. We will be more than happy to provide you with the information necessary to do so.
- Our treatment plans are always based on what the doctor believes is the best way to achieve and maintain your optimal dental health. Unfortunately insurance companies do not base benefits on this standard. Your benefits are based on the policy your employer buys from your insurance company.
- When it comes to more expensive treatment plans, even if recommended treatment is a covered benefit, it is advised to submit what's called a "Pre-Treatment Estimate". A pre-treatment is sent to your insurance company to find out what they will pay on a specific procedure. The pre treatment estimate is valid ONLY on the day it is processed. It is only a guideline to payment. Benefits may have been exhausted prior to performing the pre treated procedure, the policy may have changed, or you may no longer be covered due to leaving your job. Even if the pre estimate clearly states that a procedure will be covered, the patient may learn later that the estimated benefit will not be paid after all. This is rare, but it does happen. When it does, the patient is still obligated to pay the entire bill themselves.

TREATMENT CONSENT

Upon completion of your dental examination a treatment plan will be presented and explained to you. Questions regarding the ramifications of this treatment proposal can be discussed with your dentist or hygienist at this time. Your consent to this treatment plan is implied once you schedule an appointment to initiate treatment.

I have read, understand and agree to all terms listed above.

Signature of Patient or Guardian_____**Date**_____

HEALTH HISTORY INFORMATION

Patient Name: _____ D.O.B _____

PLEASE CIRCLE EITHER "Y" (Yes) OR "N" (No) FOR ALL:

1. Do you have or have you ever been treated for:

Y / N Asthma
Y / N High Blood Pressure
Y / N Heart Attack-Year: _____
Y / N Heart Murmur/MVP
Y / N Cardiac Stint/Pacemaker
Y / N Rheumatic Fever
Y / N Stroke/TIA-Year: _____
Y / N Artificial Joints-Year: _____

Y / N Cancer
Type: _____ Year_____
Y / N Chemotherapy
Y / N Radiation Therapy
Y / N Emphysema/COPD
Y / N Tuberculosis
Y / N Diabetes Last HA1C:_____
Last Blood Sugar: _____

Y / N Stomach Ulcers/GERD
Y / N Kidney Problems
Y / N Liver Disease/Hepatitis
Y / N Epilepsy/Seizures
Y / N Thyroid Problems
Y / N Osteoperosis
Y / N STD's
Y / N Latex Allergy

2. **Primary Care Physician's Name _____**
   Phone #: _____ Address: _____
3. What medications are you currently taking (prescribed or other): _____
   _____
4. Y / N Allergies: _____
5. Y / N Have you had joint replacement surgery or back surgery? Explain:_____
   Orthopedic Surgeon's Name: _____
   Phone #: _____ Address: _____
   Y / N Or other major surgery in the last five years? Explain: _____
6. Y / N Have you been told you have to premedicate before dental treatment? Explain: _____
   _____
7. Y / N Do you smoke? Packs Per Day: _____
   Y / N Smokeless Tobacco?
8. Y / N Do you drink? Drinks Per Week: _____
9. Y / N Do you have any disabilities? Explain: _____
10. Y / N Do you have clicking around your jaw joint?
11. Y / N Do you grind your teeth?
12. Y / N Have you ever been told you have gum problems?
13. Y / N Are you currently taking Plavix or blood thinning medications? List: _____
14. Other health information you would like to share that is not listed here: _____
    _____
    _____

For Females Only:

14. Y / N Are you pregnant? Trimester: _____
15. Y / N Are you nursing?
16. Y / N Do you take birth control pills?
17. Y / N Have you had Hormone Replacement Therapy?

To the best of my knowledge the foregoing questions have been answered accurately and I grant the right for the dentist to release health information obtained from me to third party payors (insurance company) or other health practioners.

Patient or Guardian Signature: _____ Date:_____

Doctor's Signature: _____ Date:_____

Updated on: _____	Patient Initial: _____	Reviewed By: _____
Updated on: _____	Patient Initial: _____	Reviewed By: _____
Updated on: _____	Patient Initial: _____	Reviewed By: _____
Updated on: _____	Patient Initial: _____	Reviewed By: _____
Updated on: _____	Patient Initial: _____	Reviewed By: _____