

Statement of Financial Policy

Thank you for choosing us as your dental health care provider! We are committed to the success of your treatment and care. Please understand that payment of your bill is part of this treatment and care. The following is our Statement of Financial Policy, which we require all of our patients to read, understand, and sign prior to any treatment or care.

In order for us to successfully bill your insurance company, we need complete information and require a copy of your insurance card at **each** visit. Please cooperate with our Reception Staff in providing this information.

When is Payment Due:

Payment is due at the time services are rendered in the office. If you have dental insurance the portion that is not expected to be paid by the insurance will be due at time of service. **We accept Cash, Checks, Visa and Master Card. For those who qualify, we also offer financing through Citi Health Card.**

About Your Insurance Coverage:

Your policy is a contract between you and your insurance company. Since we are not a part to the contract, your account balance is your responsibility whether your insurance pays or not. As a courtesy, we will file a claim on your behalf. We will be happy to provide your insurance company with any additional information needed to expedite the payment of your claim. However, if your insurance does not pay within 60 days, you will be responsible to pay the balance of unpaid charges and follow up with your insurance directly.

Self-Pay or Self-Filing

Patients who do not have insurance coverage, who are unable to provide us with valid insurance information or who wish to file their own insurance claims are responsible to pay 100% of charges at the time services are rendered.

About our Staff:

Our staff has been trained to understand many insurance company policies, but they **DO NOT** have all the answers about your specific benefits. Please contact your employer for a copy of your Benefits Guidebook, or call your customer service number located on the back of your insurance I.D. card to obtain detailed information about your plan coverage.

Past Due Account Balances:

If your account balance becomes past due, appropriate action will be taken to collect the amount due. If you have issues that prevent you from paying the full balance due, please contact our office so we can help find a solution. If your account is in Collections, you may be dismissed from the practice and no longer eligible for services until your balance is paid in full.

Returned Checks:

The fee for each check returned for insufficient funds is \$25. This fee will be automatically charged to your account when your check is returned from the bank.

I HAVE READ THE STATEMENT OF FINANCIAL POLICY I UNDERSTAND AND AGREE TO THE POLICY

Patient Name: _____

Signature of Patient or Guardian _____ Date _____

Patient Consent Form

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 HIPAA. I understand that you reserve the right to change the terms or this notice from time to time and that I may contact you at anytime 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.

Signed this _____ day of _____, 20__

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Medical History

For : _____ Birth Date: _____

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.

- Are you under a physician's care now? Y N If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Y N If yes, please explain: _____
- Have you ever had a serious head or neck injury? Y N If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Y N If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Y N If yes, please explain: _____
- Are you on a special diet? Y N _____
- Do you use tobacco? Y N _____
- Do you use controlled substances? Y N _____

Women, are you:

Pregnant/Trying to get pregnant? Y N Taking Oral Contraceptives? Y N Nursing? Y N

Are you allergic to any of the following:

- Asprin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
- Other (If yes, please explain:) _____

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

AIDS/HIV Positive	<input type="radio"/> Y <input type="radio"/> N	Cortisone Medicine	<input type="radio"/> Y <input type="radio"/> N	Hemophilia	<input type="radio"/> Y <input type="radio"/> N	Renal Dialysis	<input type="radio"/> Y <input type="radio"/> N
Alzheimer's Disease	<input type="radio"/> Y <input type="radio"/> N	Diabetes	<input type="radio"/> Y <input type="radio"/> N	Hepatitis A	<input type="radio"/> Y <input type="radio"/> N	Rheumatic Fever	<input type="radio"/> Y <input type="radio"/> N
Anaphylaxis	<input type="radio"/> Y <input type="radio"/> N	Drug Addiction	<input type="radio"/> Y <input type="radio"/> N	Hepatitis B or C	<input type="radio"/> Y <input type="radio"/> N	Rheumatism	<input type="radio"/> Y <input type="radio"/> N
Anemia	<input type="radio"/> Y <input type="radio"/> N	Easily Winded	<input type="radio"/> Y <input type="radio"/> N	Herpes	<input type="radio"/> Y <input type="radio"/> N	Scarlet Fever	<input type="radio"/> Y <input type="radio"/> N
Angina	<input type="radio"/> Y <input type="radio"/> N	Emphysema	<input type="radio"/> Y <input type="radio"/> N	High Blood Pressure	<input type="radio"/> Y <input type="radio"/> N	Shingles	<input type="radio"/> Y <input type="radio"/> N
Arthritis/Gout	<input type="radio"/> Y <input type="radio"/> N	Epilepsy or Seizures	<input type="radio"/> Y <input type="radio"/> N	Hives or Rash	<input type="radio"/> Y <input type="radio"/> N	Sickle Cell Disease	<input type="radio"/> Y <input type="radio"/> N
Artificial Heart Valve	<input type="radio"/> Y <input type="radio"/> N	Excessive Bleeding	<input type="radio"/> Y <input type="radio"/> N	Hypoglycemia	<input type="radio"/> Y <input type="radio"/> N	Sinus Trouble	<input type="radio"/> Y <input type="radio"/> N
Artificial Joint	<input type="radio"/> Y <input type="radio"/> N	Excessive Thirst	<input type="radio"/> Y <input type="radio"/> N	Irregular Heartbeat	<input type="radio"/> Y <input type="radio"/> N	Spina Bifida	<input type="radio"/> Y <input type="radio"/> N
Asthma	<input type="radio"/> Y <input type="radio"/> N	Fainting Spells/Dizziness	<input type="radio"/> Y <input type="radio"/> N	Kidney Problems	<input type="radio"/> Y <input type="radio"/> N	Stomach/Intestinal Disease	<input type="radio"/> Y <input type="radio"/> N
Blood Disease	<input type="radio"/> Y <input type="radio"/> N	Frequent Cough	<input type="radio"/> Y <input type="radio"/> N	Leukemia	<input type="radio"/> Y <input type="radio"/> N	Stroke	<input type="radio"/> Y <input type="radio"/> N
Blood Transfusion	<input type="radio"/> Y <input type="radio"/> N	Frequent Diarrhea	<input type="radio"/> Y <input type="radio"/> N	Liver Disease	<input type="radio"/> Y <input type="radio"/> N	Swelling of Limbs	<input type="radio"/> Y <input type="radio"/> N
Breathing Problem	<input type="radio"/> Y <input type="radio"/> N	Frequent Headaches	<input type="radio"/> Y <input type="radio"/> N	Low Blood Pressure	<input type="radio"/> Y <input type="radio"/> N	Thyroid Disease	<input type="radio"/> Y <input type="radio"/> N
Bruise easily	<input type="radio"/> Y <input type="radio"/> N	Genital Herpes	<input type="radio"/> Y <input type="radio"/> N	Lung Disease	<input type="radio"/> Y <input type="radio"/> N	Tonsillitis	<input type="radio"/> Y <input type="radio"/> N
Cancer	<input type="radio"/> Y <input type="radio"/> N	Glaucoma	<input type="radio"/> Y <input type="radio"/> N	Mitral Valve Prolapse	<input type="radio"/> Y <input type="radio"/> N	Tuberculosis	<input type="radio"/> Y <input type="radio"/> N
Chemotherapy	<input type="radio"/> Y <input type="radio"/> N	Hay Fever	<input type="radio"/> Y <input type="radio"/> N	Pain in Jaw Joints	<input type="radio"/> Y <input type="radio"/> N	Tumors or Growths	<input type="radio"/> Y <input type="radio"/> N
Chest Pains	<input type="radio"/> Y <input type="radio"/> N	Heart Attack/Failure	<input type="radio"/> Y <input type="radio"/> N	Prathyroid Disease	<input type="radio"/> Y <input type="radio"/> N	Ulcers	<input type="radio"/> Y <input type="radio"/> N
Cold Sores/Fever Blisters	<input type="radio"/> Y <input type="radio"/> N	Heart Murmur	<input type="radio"/> Y <input type="radio"/> N	Psychiatric Care	<input type="radio"/> Y <input type="radio"/> N	Venereal Disease	<input type="radio"/> Y <input type="radio"/> N
Congenital Heart Disorder	<input type="radio"/> Y <input type="radio"/> N	Heart Pace Maker	<input type="radio"/> Y <input type="radio"/> N	Radiation Treatments	<input type="radio"/> Y <input type="radio"/> N	Yellow Jaundice	<input type="radio"/> Y <input type="radio"/> N
Convulsions	<input type="radio"/> Y <input type="radio"/> N	Heart Trouble/Disease	<input type="radio"/> Y <input type="radio"/> N	Recent Weight Loss	<input type="radio"/> Y <input type="radio"/> N		

Have you ever had any serious illness not listed above? Y N If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in the medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN: _____ DATE: _____

ABOUT YOU

Today's Date: _____

Social Security #: _____

Name: _____
LAST FIRST MIDDLE INITIAL

I like to be called: _____

Home Address : _____

APT # CITY STATE ZIP

Mailing Address, If Different:

Address: _____

APT # CITY STATE ZIP

Your Employer: _____

Occupation: _____ How long held: _____

Birthday: ____/____/____ Male Female

Single Married Divorced Widowed

Special interests, sports or hobbies: _____

Referred by: _____

RESPONSIBLE PARTY

Name: _____ Relationship: _____

Address: _____

Home Phone # _____ Work Phone # _____

TELEPHONE

Home Phone: _____

Work Phone: _____ Ext. #: _____

When is the best time In reach you? _____

Where? _____ Spouse's employer's phone #: _____

In the event of an emergency, is there someone who lives near you that we could contact?

Name: _____ Relationship: _____

Work #: _____ Home #: _____

INSURANCE INFORMATION

PLEASE COMPLETE IF YOU HAVE DENTAL INSURANCE

Primary Insurance Co. Name: _____

Insurance Company's Address: _____

City, State, Zip _____

Insured's ID # _____ Group Plan # _____

PLEASE COMPLETE IF YOU HAVE ADDITIONAL DENTAL INSURANCE

Secondary Insurance Co. Name: _____

Insurance Company's Address: _____

City, State, Zip _____

Insured's ID # _____ Group Plan # _____

POLICYHOLDER INFORMATION

Complete the information below if PATIENT is NOT the POLICYHOLDER

Primary Policyholder's Name _____

Primary Policyholder's Address _____

City, State, Zip _____

Telephone _____

Birthday: ____/____/____ Male Female

Employer's Name or School Name _____

Employer's Phone _____

Employer's Address _____

City, State, Zip _____

Social Security #: _____

Relationship to Patient: Spouse Parent Other _____

Employer Plan Coverage: Yes No

If Champus: Active Retired Deceased

Branch of Service: _____

RELEASE INFORMATION

I authorize the release of any dental information necessary to process by claim.

Signature: _____

AUTHORIZATION PAYMENT TERMS

I hereby authorize payment directly to the Dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment and that if I default in any way as to the payment of said costs, then I agree to pay all costs of collection including reasonable attorney's fees. I hereby authorize the Dental Office to administer such medication and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

Signature of responsible party

State driver's license number