Date:_____

Patient's Name _____
Last First Middle

Mailing Address _____
Address City State Zip

Patient Date of Birth _____Patient S/S#_____ Female/Male Married/Single/Child/Other

EMAIL_____

Home Ph. _____ Work Ph. _____ Cell Ph._____

Employer _____ Occupation_____

If patient is a <u>minor</u>, Responsible party information: Name: _____
Last First Middle

Spouse's Name _____
Last First Middle

Spouse's Employer _____Spouse's Occupation _____

Is an immediate family member a patient here? _____ Name_____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Self _____ Other _____
Yes/No Last First Middle

If "other" please complete:
Date of Birth _____ S/S#_____ Relationship to Patient _____

Address _____
Street City State Zip

How long at this address _____ Home Ph. _____ Work Ph. _____

Dental Insurance Information

Insured's Name _____ S/S#_____ Date of Birth_____

Insured's Employer _____
Zip

Insurance Company _____ Group No. _____ ID No. _____

Insurance Co. Address _____

Do you have any dual dental coverage? ☐Yes ☐No

Insured's Name _____ S/S#_____ Date of Birth_____

Insured's Employer _____
Zip

Insurance Company _____ Group No. _____ ID No. _____

Insurance Co. Address _____

Emergency Information

Name of nearest relative not living with you _____

Address _____ Phone number_____

Reason for today's visit _____

1. Are you having pain or discomfort at this time?..... Yes No
2. Have you been a patient in the hospital during the past two years?..... Yes No
3. Have you been under the care of a medical doctor during the past two years?..... Yes No

Physician's Name _____

Address _____ _____ Phone No. _____

4. Have you taken any medication or drugs during the past two years?..... Yes No
5. Are you now taking any medication, drugs, or pills?..... Yes No

If yes, please list: _____

_____

6. Are you currently taking aspirin daily? Yes No What dose?_____

7. Do you take a blood thinner? Yes No Name of Med_____ Dose_____

8. Do you require a pre-medication (Antibiotic) for dental visits? Yes No Medication: _____ Dose:_____

9. Are you aware of being allergic to or have you ever reacted adversely to any medication or substances?..... Yes No

If yes, please list: _____

10. Indicate which of the following you have had or have at present. Check "yes" or "no" to each item.

Heart Murmur…….	Yes	No	Venereal Disease……..…	Yes	No	Diabetes……..Yes		No
Heart Pacemaker……..…	Yes	No	Hepatitis A (infectious)……	Yes	No	Thyroid Problems…….	Yes	No
Mitral Valve Prolaspe……	Yes	No	Hepatitis B (serum)……..	Yes	No	Tuberculosis…….	Yes	No
High Blood Pressure……..	Yes	No	Hepatitis C…….…….……	Yes	No	Asthma…….	Yes	No
Heart Surgery…….	Yes	No	A.I.D.S…..…….….	Yes	No	Artificial Joints……	Yes	No
Rheumatic Fever……	Yes	No	H.I.V. Positive……..……..	Yes	No	Psychiatric Treatment….	Yes	No
Epilepsy or Seizures……..	Yes	No	Bleeding Problems / Hemophilia…..	Yes	No	Cortisone Medicine……	Yes	No
Fainting or Dizzy Spells……	Yes	No	Radiation Therapy……..……	Yes	No	Cancer…….	Yes	No
Latex allergy…….	Yes	No	Dementia/ Alzheimers……..……Yes		No	Cancer type: _____		

11. Do you Smoke? Yes No If yes: # of packs per day _____ ; # of Cigarettes per day_____
12. Do you use Smokeless Tobacco? Yes No

For Women Only:

Are you pregnant? ☐ Yes, what month? _____ ☐ No
Are you nursing? ☐Yes ☐ No
Are you taking birth control pills? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature_____ Date_____

Consent:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with (name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time of services are rendered unless financial arrangements have been made. I further understand that a 1 ½% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

ANY PORTION OF A REMAINING BALANCE AFTER NINETY (90) DAYS WILL BE SENT TO A COLLECTION AGENCY.

Patient_____ Date_____ Witness_____

Parent or Responsible Party_____ Relationship to Patient_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this
NAME

Office's Notice of Privacy Practices.

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security # : _____

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received you revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

FINANCIAL POLICY

INSURANCE

1. Patient and/or responsible parties who have dental or health insurance should remember that professional services are provided and charged to the patient/responsible party, not the insurance company. Allowing time for the insurance company to process claims before collecting our fee is a courtesy we *may* extend to our patients- not an obligation.
2. We will submit insurance claims for the patient and/or responsible party unless other arrangements have been made.
3. We will ESTIMATE, to the best of our ability, the amount your insurance company will pay. We ask that you pay the difference between ESTIMATED coverage and the cost of the procedure at the time of service.
4. Should insurance pay more than the estimated amount, our office will gladly refund the difference.
5. Insurance companies pay benefits based on fees that they determine according to contracts negotiated with employers and/or individuals. They term these benefits "reasonable and customary rated" which may or may not be the prevailing fees in the area. The fees charged in our practice fall within most insurance company's "reasonable and customary rates". However, those who have a contract with a lesser quality insurance company, or those whose employers have purchased inferior plans may have "reasonable and customary rates" that fall below actual charges. Should this occur, the patient and/or responsible party is liable for the balance not covered by insurance. We will not be forced to let monetary considerations and insurance company policies interfere with providing the best possible care to our patients.
6. If a patient's insurance requires hospitalization to be predetermined, it is the patient's responsibility to notify our office.
7. The parent that accompanies a minor to the office will be responsible for the fees unless other arrangements have been made prior to the date of service.
8. (For DELTA Premier patients) Sixty days will be allowed for your insurance company to process the claim. If, after sixty days, no notice has been received from your insurance company, it is your responsibility to contact them directly. Regarding your insurance, you should remember that the entire balance is your responsibility at that time.

LATE FEES AND/OR COLLECTION COSTS

1. A finance charge of 12% annually will be applied to any unpaid balance thirty (30) days after the date of service is rendered or thirty days after you insurance company has paid.
2. If, after sixty (60) days from the date of service your insurance company has failed to pay, your account will be subject to the finance charge.
3. If any balance is overdue and Legal or Collection assistance becomes necessary, the responsible party (guarantor) will be liable for charges incurred.

This signature is on file as my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to Admired Smiles of the insurance benefits otherwise due.

I have read the above financial policy and agree to the terms outlined therein.

Patient/Parent, Guarantor or Legal Guardian _____ Date _____

ATTENTION INSURANCE COVERAGE PATIENTS

As a courtesy to our patients, we will bill your insurance company for the treatment you receive.

We will **ESTIMATE**, to the best of our ability, the amount your insurance company will pay. We ask that you pay the difference between **ESTIMATED** coverage and the cost of the procedure at the time of service.

Should insurance pay more than the estimated amount, our office will gladly refund the difference.

NON PAYMENT

In the event that your insurance company has not paid any or all of the **ESTIMATED** coverage amount after 2 months, you, the patient, are still liable and you will be asked to pay the balance in full at that time.

You may wish to pursue the claim with your insurance company personally and we are happy to provide you with appropriate documentation.

NEW PATIENTS

If we are not able to confirm insurance coverage prior to your appointment, payment for the entire procedure will be due at the time of service.

****

I have read the above information and understand that regardless of any insurance claim, I am responsible for all unpaid fees.

_____

Patient (print name)

_____

Signature (responsible party)