Allentown Dental

GENERAL DENTISTRY

Welcome to our office! In order to provide you with better care, we require the following information and medical history. <u>All information is considered confidential.</u>

Name _____Today's date _____

Address _____City _____Zip _____

Home phone _____ Cell Phone _____Work phone _____

May we contact you at work? (*Circle one*) Yes No If no, in an emergency? Yes No

Date of Birth _____Occupation _____

Social Security No._____ Spouse's name _____

E-mail address (if applicable) _____

Would you like to receive appointment/recall information by email? Yes No

May we confirm your appointments by text? Yes No

Is anyone else responsible for your account financially? Yes No
If yes, please give that information to our front desk staff.

<u>If you have dental insurance:</u>

Dental Insurance carrier _____ Name of Insured _____

Insured's employer _____Insured's Social Security No. _____

Relationship to insured (self, spouse, child) _____Insured's D.O.B _____

<u>If you are a new patient to our office:</u>

How did you hear about our office? _____

When was your last dental appointment? _____

Have you ever been referred to a periodontist? _____

Have you had dental x-rays taken anywhere else in the last 3 years? _____

Patient Name_____

Medical History

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 interrelationahip with the dentistry you will receive. Thank you for answering the following questions.

Do you have a primary care physician? __ Yes __ No Physician's name:_____
Have you ever been hospitalized or had a major operation? __ Yes __ No If yes, please explain:_____
Have you ever had a serious head or neck injury? __ Yes __ No If yes, please explain:_____
Do you use tobacco? __ Yes __ No

Are you taking any medications, pills, or drugs including vitamins or herbal supplements? __ Yes __ No

If yes, Please list (or bring printed list)

_____
_____
_____

Women: Are you:

Pregnant/Trying to become pregnant? __ Yes __ No Taking oral contraceptives? __ Yes __ No Nursing? __ Yes __No

Being treated with any osteoporosis medication such as Actonel or Fosamax? ___Yes ___No

Are you allergic to any of the following:
___Aspirin ___Penicillin __Codeine ___Acrylic ___Metal ___Latex ___ Erythromycin ___Local Anesthetics

___Other If yes, please explain:_____

Do you have, or have you had, any of the following? (please check any that apply)

____AIDS/HIV Positive	____Congenital Heart Disorder	____Herpes
____Alzheimer's Disease	____Convulsions	____High Blood Pressure
____Anaphylaxis	____Cortisone Medicine	____Hypoglycemia
____Anemia	____Diabetes	____Irregular Heartbeat
____Angina	____Drug Addiction	____Low Blood Pressure
____Arthritis	____Emphysema	____Pain in Jaw Joints
____Artificial Heart Valve	____Epilepsy or Seizures	____Psychiatric Care
____Artificial Joint	____Excessive Bleeding	____Radiation Treatments
____Asthma	____Frequent Headaches	____Shingles
____Blood Disease	____Glaucoma	____Sinus Trouble
____Blood Transfusion	____Hay Fever	____Stroke
____Breathing Problem	____Heart Attack/Failure	____Swelling of Limbs
____Bruise Easily	____Heart Pace Maker	____Thyroid Disease
____Cancer	____Heart Trouble/Disease	____Tonsillitis
____Chemotherapy	____Hemophilia	____Tuberculosis
____Chest Pains	____Hepatitis A	____Tumors or Growths
____Cold Sores/Fever Blisters	____Hepatits B or C	____Ulcers

Have you ever had surgery or radiation for a tumor, cancer diagnosis or condition of the head and neck? (If yes, please explain)

_____

Person to Contact in Case of Emergency:_____Emergency Contact Phone #_____

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 medical status.

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Patient/Guardian Name _____ Date of Birth _____

Patient Treatment and Financial Policy

Thank you for choosing our office as your dental provider. We are committed to providing you with the highest quality dental care, so that you may obtain optimum oral health.

The following statement is our Financial Policy, which we require that you read, agree to, and sign prior to any treatment.

Please note: Payment is due at the time of service provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express, and CareCredit. Additional Fees will be applied for returned checks. All account balances over 90 days are subject to a $35 late fee.

Do you have dental insurance?

- **You need to bring** your insurance card and coverage booklet at your first visit, and at any time your insurance changes.
- **We will always do our best** to help you maximize your benefits.
- **Although we file claims for you as a courtesy,** your dental insurance policy is a contract between you, your employer, and your insurance company. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. We will do all we can do to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan.
- **Not all services are covered benefits in all contracts.** Some insurance companies arbitrarily select certain services they will not cover. It is your responsibility to thoroughly understand the coverage and exceptions of your particular policy. We are happy to help with this.
- **We ask that you** pay the deductible, co-payment, and co-insurance, which is the estimated amount not covered by your insurance company, at the time we provide service to you.
- **Insurance payments are ordinarily received within 30-60 days** from the time of filing the claim. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment

is not received or your claim is denied, you will be responsible for paying the full amount at that time.

- **We will cooperate fully** with the regulations and requests of your insurance company that may assist in your claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Outstanding balances on your account are discouraged, and must be cleared before the next appointment for any account member or within 30 days of treatment. Delinquent balances over 90 days old will be referred to a collection agency. All referred accounts are marked "Inactive". In order to have your account "Reactivated" and continue receiving dental treatment in our office, delinquent balances must be paid in full.

Your dental appointments are scheduled carefully. Our goal is to provide treatment in a timely manner with as few visits as necessary. Time, trained personnel and dental equipment are reserved for each procedure. In order to provide the best service to our patients, we require at least a 24 hour notice for cancellations or for re-scheduling your appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. If you know that you are unable to keep your appointment, we ask you show consideration by canceling your appointment at least 24 hours in advance. This allows us adequate time to schedule another patient who needs to be seen. A fee will be incurred for missed appointments and short notice cancelations. Multiple failed appointments may result in being dismissed from the dental practice.

Consent:
I have read, understand, and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by said insurance and I agree to pay such charges in full. I also hereby authorize the release of pertinent medical/dental information to the insurance carrier.

_____ _____

Patient (or Guardian of minor) Date

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Patient HIPAA 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 our 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 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 _____ Date _____

Signature _____