



Financial Policy

Welcome to our office. We are honored that you have chosen us as your dental health care provider. Quality dental care is a financial investment. If you have insurance benefits, we will work with you to help you understand and maximize your coverage. Insurance companies and coverage can vary. Your contract for insurance benefits exists between you and your insurance carrier. Please remember that you are ultimately responsible for your account with our office.

- ★ We accept payment for services by cash, check, MasterCard, Visa and Discover.
- ★ If you have dental insurance, we will be happy to file your claim(s) for you as a courtesy. Ultimately, what insurance does not cover is the responsibility of the patient.
- ★ You will receive an estimate of your liability prior to any appointments so that you will be financially prepared. Please remember that, regardless of insurance coverage, you are responsible for your account with our office.
- ★ When treatment is rendered, our staff will fully brief you on the costs and ask that your estimated copayment and deductible be paid at the time of service. We may require a deposit at the time of appointment for some services that cost more than \$200. Our office will let you know of any required deposit in advance. We will file insurance claims and accept assignment of benefits. After receiving payment through your insurance, we will send a statement with any balances due or credits. We ask that payment be made within 14 days of the statement. In the event of a credit, we will promptly issue a refund. In the event that your insurance does not pay within 45 days, we ask that you make payment in full and contact your insurance company regarding reimbursement to you.
- ★ Fees quoted will be accepted for 90 days. In the event that clinical conditions warrant a different treatment, you will be notified of changes prior to the procedure.
- ★ All accounts in which effort to pay is not made will be subject to collection proceedings.
- ★ Our office requires a 24-hour notice for any canceled appointments. A 25\$ fee may be assessed for Canceling an appointment without 24-hour notice.

Thank you for reviewing our financial and insurance policy. We will make every effort to explain your costs to you before treatment so we can avoid misunderstandings and focus on your dental health. If you have any questions, please ask—we are here to serve you.

I have read, understand, and agree to abide by this policy. I have been given the opportunity to receive a copy of this document.

Account Holder's Signature

Print Name

Date



HIPAA Compliance

PATIENT NAME _____

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations. As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest. We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name _____

Signature _____ **Date** _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the “Privacy Rule.” We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: _____ Date of birth: _____ Sex: _____ Age: _____

Home address: _____ City: _____ State: _____ Zip: _____

Billing address (if different): _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ E-mail: _____ Driver's license #: _____ State: _____

SS #: _____ Employer/Occupation: _____ Bus. Phone: _____

Spouse's name & phone #: _____ Emergency phone # (other than spouse): _____

Primary dental insurance: _____ Group #: _____

Secondary dental insurance: _____ Group #: _____

Subscriber's name: _____ Date of birth: _____ SS #: _____

Name of your medical doctor: _____ Date of last visit to medical doctor: _____

Name of previous dentist: _____ Date of last visit to dentist: _____

Referred to us by: _____

DENTAL HEALTH HISTORY

	Yes	No
Are you apprehensive about dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had problems with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Do you gag easily?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear dentures?	<input type="checkbox"/>	<input type="checkbox"/>
Does food catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty in chewing your food?	<input type="checkbox"/>	<input type="checkbox"/>
Do you chew on only one side of your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you avoid brushing any part of your mouth because of pain?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed easily?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when you floss?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums feel swollen or tender?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever noticed slow-healing sores in or about your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?	<input type="checkbox"/>	<input type="checkbox"/>
Cold foods or liquids?	<input type="checkbox"/>	<input type="checkbox"/>
Sours?	<input type="checkbox"/>	<input type="checkbox"/>
Sweets?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take fluoride supplements?	<input type="checkbox"/>	<input type="checkbox"/>
Are you dissatisfied with the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you prefer to save your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you want complete dental care?	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
How often do you brush?	_____	_____
How often do you floss?	_____	_____
Does your jaw make noise so that it bothers you or others?	<input type="checkbox"/>	<input type="checkbox"/>
Do you clench or grind your jaws frequently?	<input type="checkbox"/>	<input type="checkbox"/>
Do your jaws ever feel tired?	<input type="checkbox"/>	<input type="checkbox"/>
Does your jaw get stuck so that you can't open freely?	<input type="checkbox"/>	<input type="checkbox"/>
Does it hurt when you chew or open wide to take a bite?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have earaches or pain in front of the ears?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any jaw symptoms or headaches upon awaking in the morning?	<input type="checkbox"/>	<input type="checkbox"/>
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	<input type="checkbox"/>	<input type="checkbox"/>
Do you find jaw pain or discomfort extremely frustrating or depressing?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a temporomandibular (jaw) disorder (TMD)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	<input type="checkbox"/>	<input type="checkbox"/>
Are you unable to open your mouth as far as you want?	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of an uncomfortable bite?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a blow to the jaw (trauma)?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a habitual gum chewer or pipe smoker?	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL HEALTH HISTORY:

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

	Yes	No
Heart Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain _____	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure problem _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve problem _____	<input type="checkbox"/>	<input type="checkbox"/>
Taking heart medication _____	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever _____	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker _____	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising _____	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nosebleeds _____	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease (anemia) _____	<input type="checkbox"/>	<input type="checkbox"/>
Ever require a blood transfusion? _____	<input type="checkbox"/>	<input type="checkbox"/>
Allergy Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Skin rashes _____	<input type="checkbox"/>	<input type="checkbox"/>
Taking allergy medication _____	<input type="checkbox"/>	<input type="checkbox"/>
Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>
Intestinal Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers _____	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain or loss _____	<input type="checkbox"/>	<input type="checkbox"/>
Special diet _____	<input type="checkbox"/>	<input type="checkbox"/>
Constipation/Diarrhea _____	<input type="checkbox"/>	<input type="checkbox"/>
Kidney or bladder problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Bone or Joint Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
Back or neck pain _____	<input type="checkbox"/>	<input type="checkbox"/>
Joint replacement _____	<input type="checkbox"/>	<input type="checkbox"/>
(e.g., total hip, pins, or implants)		
Fainting Spells, Seizures, or Epilepsy _____	<input type="checkbox"/>	<input type="checkbox"/>
Stroke(s) _____	<input type="checkbox"/>	<input type="checkbox"/>
Frequent or severe headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough or swollen glands _____	<input type="checkbox"/>	<input type="checkbox"/>
Premedications required by physician _____	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Tumor _____	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>
Urinate more than 6 times a day _____	<input type="checkbox"/>	<input type="checkbox"/>
Thirsty or mouth is dry much of the time _____	<input type="checkbox"/>	<input type="checkbox"/>
Family history of diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis or other respiratory disease _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much? _____		
Do you smoke? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much? _____		
Hepatitis, jaundice, or liver trouble _____	<input type="checkbox"/>	<input type="checkbox"/>
Herpes or other STD _____	<input type="checkbox"/>	<input type="checkbox"/>
HIV-positive/AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contact lenses? _____	<input type="checkbox"/>	<input type="checkbox"/>
History of head injury? _____	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or other neurological disease? _____	<input type="checkbox"/>	<input type="checkbox"/>
History of alcohol or drug abuse? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any disease, condition, or problem not listed previously that you feel we should know about? _____		
If so, please describe: _____		

During the past 12 months, have you taken any of the following?

	Yes	No
Antibiotics or sulfa drugs _____	<input type="checkbox"/>	<input type="checkbox"/>
Anticoagulants (e.g., Coumadin) _____	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure medicine _____	<input type="checkbox"/>	<input type="checkbox"/>
Tranquilizers _____	<input type="checkbox"/>	<input type="checkbox"/>
Insulin, Orinase, or similar drug _____	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin _____	<input type="checkbox"/>	<input type="checkbox"/>
Digitalis or drugs for heart trouble _____	<input type="checkbox"/>	<input type="checkbox"/>
Nitroglycerin _____	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone (steroids) _____	<input type="checkbox"/>	<input type="checkbox"/>
Natural remedies _____	<input type="checkbox"/>	<input type="checkbox"/>
Nonprescription drug/supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Are you allergic, or have you reacted adversely, to any of the following?

	Yes	No
Local anesthetics ("Novocaine") _____	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics _____	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs _____	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills _____	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin, Acetaminophen, or Ibuprofen _____	<input type="checkbox"/>	<input type="checkbox"/>
Codeine, Demerol, or other narcotics _____	<input type="checkbox"/>	<input type="checkbox"/>
Reaction to metals _____	<input type="checkbox"/>	<input type="checkbox"/>
Latex or rubber dam _____	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Notes: _____

_____ **Date:** _____

Women

	Yes	No
Are you taking contraceptives or other hormones? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, expected delivery date: _____		
Are you nursing? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you reached menopause? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, do you have any symptoms? _____		

Notes: _____

Patient/Parent Signature: _____

Dentist Initial: _____