Patient Information

Patient Name: _____ Date: _____
Last, First, Middle Initial. (Preferred Name)

Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Child

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell Phone): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV
☐ Allergies _____
_____
☐ Anemia
☐ Artificial Joints
Date_____ Joint_____
☐ Asthma
☐ Blood Disease
☐ Cancer-Type_____
☐ Chemotherapy
☐ Diabetes
☐ Dizziness/ Fainting
☐ Epilepsy
☐ Excessive Bleeding or Clotting Problems
☐ Hay Fever
☐ Head/Facial Injuries
☐ Hearing Loss
☐ Heart Disease
☐ Heart Murmur/MVP
☐ Hepatitis
☐ High Blood Pressure
☐ Kidney Disease
☐ Latex Allergy
☐ Liver Disease
☐ Mental Disorders
☐ Pacemaker
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Sinus Problems
☐ Stomach/GI Problems
☐ Stroke
☐ Thyroid Disorders
☐ Tuberculosis
☐ Tumors/ Growths
☐ Venereal Disease
☐ Surgeries-Date_____
Type_____

- Females: Are you pregnant? ☐ Yes ☐ No If yes, Due Date: _____
- Females: Are you nursing? ☐ Yes ☐ No
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
  Please list current medications you are taking _____
  Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you or have you used any tobacco products (i.e. cigarettes, cigars, chew, snuff)? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you ever taken medications called bisphosphonates (Aredia, Zometa, Fosamax, Actonel, Didronel, Skelid, Bonefos, Boniva, etc.)?
  ☐ Yes ☐ No If yes, was/is it oral or I.V. ☐ Oral ☐ I.V.
  If yes, please explain (type, when, what for): _____

Please circle all of the following conditions that you experience on a regular basis.

Bad breath , Biteguard therapy , Bleeding gums , Bleaching treatment , Blisters/sores in mouth or on lips , Chewing your nails ,

Burning sensation on tongue , Clench/grind teeth , Gums swollen/tender , Jaw pain/tired , Loose teeth , Mouth breathing ,

Pain around ear , Past periodontal treatment , Sensitivity to hot, cold, or sweets , Thumb sucking , Wisdom teeth removed in past

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient _____ ☐Insurance Company

☐ Another Dental Office _____ ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell Phone): _____

Address: _____
Street

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I further agree that if this account is turned over to a collections agency, I will be responsible for all collection agency fees up to 35% of the principal balance, with interest of 21% A.P.R., court costs and reasonable attorney fees.

I grant my permission to you or your assignee, to telephone me at my primary phone number to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date_____ Relationship to Patient_____
Signature of payment/responsible party

DANVILLE FAMILY DENTISTRY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Health Insurance Portability Accountability Act (HIPAA), 1996

http://www.hhs.gov/ocr/hipaa/finalreg.html

SECTION A: PATIENT/GUARDIAN GIVING CONSENT

Name: _____

Address: _____

Telephone:_____ E-mail: _____

Social Security #: _____

SECTION B: TO THE PATIENT/GUARDIAN — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

DANVILLE FAMILY DENTISTRY

JON ERICKSON, DDS

PO Box 486

23 S. COUNTY RD 200 E STE #B

DANVILLE, IN 46122

(317) 745-4400

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 your 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. PLEASE ADVISE US IF YOU WANT A COPY.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

Acknowledgement of Receipt

Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement that you have been notified that our ***NOTICE OF PRACTICE POLICIES*** can be obtained via our office. This document is printable via the web-site for your records.

HIPAA web-site:**http://www.hhs.gov/ocr/hipaa/finalreg.html**

- **You May Refuse to Sign This Acknowledgement***

I, : _____ , have received acknowledgement of this office's Notice of Privacy Practices. Date: _____

Signature

For Office Use

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)

_____

IMPORTANT DENTAL INSURANCE INFORMATION FOR OUR PATIENTS

Understanding your insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits. We care for patients from may different companies. Each company pays an insurance premium for specific coverage, which fits the company budget. Each plan is slightly different in covered services. It is **your** responsibility to become familiar with your policy exclusions, deductibles and required co-payments.

OUR COURTESY SERVICE TO YOU INCLUDES:

1. Filing your insurance within 24 hours of your visit and requesting payment of your benefit to our office.
2. Electronically filing your insurance for short turnaround.
3. Researching your dental insurance plan to advise you of benefits available to you.
4. Re-filing your insurance claim a second time within 30 days if it has not paid.
5. Following the American Dental Association guidelines for coding procedures and filing insurance.

OUR EXPECTATIONS OF YOU AS THE OWNER OF THE POLICY:

1. Payment of fees NOT covered by your insurance plan at the time the service is delivered.
2. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
3. Realizing that dental insurance policies restrict payment for some services, use restricted fee schedules (called Usual and Customary Rates) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for insurance not our fees or recommended treatment.
4. Taking responsibility for payment if the insurance company does not pay our office within 60 days.
5. Keeping our office informed of any changes in your insurance coverage or employment.

Thank you for your cooperation with your dental insurance coverage. Please sign the space below and have your insurance card ready for us to copy for our file.

I hereby authorized Danville Family Dentistry to release to my insurance company information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Danville Family Dentistry. I understand I am responsible for any unpaid balance.

_____ _____

Signature of Patient/Insured Date