Patient Information

Welcome to our office! To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.

Patient Name: ____ Preferred Name: ___________________
Last First MI

□ Male □ Female □ Married □ Single □ Child

Birth Date __________________________________ Social Security Number _____________________

Phone (Home): __________________ (Work): _________________ Ext: _______ Cell: ______________

Mailing Address: ____
Street Apartment #

City: ______________________________ State _______________ Zip __________________

Email Address _____________________________________

Employer ______________________________________ Occupation ___________________________

If a minor, Parent's Name(s) ____

Medical Health Information

Date of Last Dental Visit: _______________________ Reason for today's visit: _________________________

Do you have or have you ever had any of the following?
(Please check any that apply, and circle appropriate medical issue)

□ Abnormal bleeding after extractions, surgery, or trauma
□ AIDS/HIV
□ Anemia or Blood Disorders
□ Artificial Joint or Valve
□ Arthritis
□ Asthma / Difficulty Breathing
□ Blood Transfusion
□ Cancer or Tumor
□ Diabetes
□ Epilepsy, Seizures, or Fainting Spells
□ Heart Disease
□ Heart Murmur, Mitral Valve Prolapse, Heart Defect
□ Hepatitis
□ Herpes or Cold Sores
□ High or Low Blood Pressure
□ Kidney Disease
□ Liver Disease
□ Pacemaker
□ Rheumatic Fever or Rheumatic Heart Disease
□ Tuberculosis or other Lung Problems

Do you smoke or use chewing tobacco? □ Yes □ No
Have you ever been told you need to pre-med before any Dental Treatment? □ Yes □ No
If so, why? ______________________________

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

□ Aspirin
□ Barbiturates, Sedatives, Sleeping Pills
□ Codeine or other Narcotics (please specify) ___________
□ Latex materials
□ Local Anesthetics (Novocaine)
□ **Penicillin** or other Antibiotics (please specify) __________
□ Sulfa Drugs
□ Other: ________________________________

Are you taking any of the following medication?

□ Anticoagulants (blood thinners)
□ Aspirin
□ Osteoporosis (bone density) medicine

List All Medications, Vitamins, Herbs, Etc:

____
____
____
____
____
____
____
____

Women:

□ Pregnant or May be pregnant
Expected Delivery Date: ____________________

- Name of Physician: ______________________________________ Phone: ____________________
- Do you have any health problems that are not listed above? □ Yes □ No
  If yes, please explain: ____
- Have you ever had a bad reaction or bad experience from a Dental Visit? ___________________________

Signature of patient (or parent) ______________________________________ **Date** ____________________

Spouse and/or Responsible Party Information

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

Name: ____

◻ Male ◻ Female ◻ Married ◻ Single

Social Security #: ______________________________________ Birth Date: ______________________________

Phone (Home): ____________________ (Work): ___________________ Ext: __________ Cell: _______________

Mailing Address:____

City: ______________________________ State:________________ Zip: _______________________

◊◊◊ Insurance Information ◊◊◊

Please present your insurance card(s)* for us to photocopy*!

We must have the following information in order to send your insurance claim:

Subscriber Name, DOB, SSN, Insurance ID Number, Name of Insurance Company, Mailing Address, Telephone Number, Group Number or Policy Number.

Referral Information

Whom may we thank for referring you to our practice? ◻ Another patient, Name ___________________ ◻ Internet

◻ Dental Office (name)______________ ◻ Yellow Pages ◻ Newspaper ◻ Signs ◻ TV Ad ◻ Other_____________

◊◊ 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/my dependent(s) health, I will inform the doctor and staff at the next appointment without fail.

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 he or she is personally responsible for payment of all dental services. This office will help prepare the patient's 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 the insurance company.

A service charge of 1 ½% 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 be 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 grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content. **I give permission for Dr. Boone's office to take necessary x-rays of myself or my minor child/dependent.**

____ Date: _____________ Relationship to Patient: _________________________

Signature of patient, parent or guardian

____ Date: _____________ Relationship to Patient: _________________________

Signature of guarantor of payment/responsible party

Financial Policy

- Effective October 1, 2012, the office requires a copy of your driver's license. Payment is expected at time of service. Failed appointments or appointments cancelled or rescheduled with less than a 24 hour notice are subject to a $25.00 charge.
- All lab crowns, dentures, partials, and other lab procedures require full patient payment or co- payment at beginning of treatment. Balances for CEREC crowns and onlays are due at time of service. Work cannot be financed in office.
- Patients with dental insurance ***will be responsible for deductibles and co-payments at time of service.***
- Patients who have a relationship with an insurance company paying the patient directly will be responsible for payment at time of service. Regardless of dental insurance coverage, the patient or guarantor is responsible for all account balances.
- As a courtesy to patients, Dr. Boone will file dental insurance; however, Dr. Boone is only a participating provider with Delta Dental Premier and Cigna. Most other insurance companies will be filed as a courtesy, and patients will be responsible for any portion not covered by the insurance at the time of appointment. Dental insurance is a contract between the employer and the insurance company and the employer and the employee. We may agree to file secondary insurance as a courtesy for the patient, with the stipulation the patient must sign a credit card authorization form for any charges not paid by both insurances and any co-payment that may due. We will call the patient before charging out any balance, giving them a 7-day grace period to pay with cash or check if they choose to.
- Options for payment include cash, check, Third party financing or credit card (Visa, MC, Discover). We do not extend payment plans directly from our office, but we do offer 0% with our 3rd party financing group.
- We do not file auto insurance or homeowner's insurance or send bills to an attorney for payment. We do not hold accounts for settlement of accident claims, and we do not accept workman's compensation.
- Any balance considered delinquent or any check returned by your bank will be forwarded to our collection agency. As of October 1, 2012, debtor is responsible for all legal and collection fees related to collection.
- There will be a $ 25.00 fee for all returned checks.
- Patients whose balances are referred for collection will no longer be seen in the office.
- Interest or a monthly late charge will be added to accounts deemed delinquent by the office. The interest rate will be 1.5%; the billing charge is $4.00. Any late charge for non-payment will result in a $35.00 per month extra fee.

Printed Name | Signature | Date

Important Dental Insurance Information for Our Patients

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

Our courtesy to you includes:

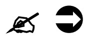
- Electronically filing your insurance within 24 hours of your visit and requesting payment of your benefit to our office.
- Helping you understand your dental insurance plan to advise you of benefits available to you.
- Re-filing your insurance a second time at 30 days.
- Following the American Dental Association guidelines for coding procedures and filing insurance.
- As a courtesy to patients, Dr. Boone will file dental insurance. However, Dr. Boone is only a participating provider with Delta Dental Premier and Cigna. Most other insurance companies will be filed as a courtesy, and patients will be responsible for any portion not covered by the insurance at the time of appointment. The dental insurance is a contract between the employer and the insurance company, not between Dr. Boone and the insurance company.

Our expectations of you as the owner of the policy:

- *Understanding that payment of fees not covered by your insurance plan are payable at the time the procedure is started.*
- Understanding that the insurance policy belongs to you, and we have no leverage to obtain payment from your insurance company.
- *Those patients who have a relationship with an insurance company paying the patient directly will need to pay for treatment at time of service. Regardless of dental insurance coverage, the patient or guarantor is responsible for the account.*
- Understanding 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.
- Taking responsibility for payment if the insurance company does not pay our office after 60 days.
- *Keeping our office informed of any changes in your insurance coverage or employment. Failure to do this will result in our asking for payment of the insurance charges immediately and $5.00 insurance refilling fee. No exceptions.*

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

I hereby authorize Dr. Boone to release to my insurance company information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Dr. Alison L. Boone. This also applies to my dependents: ________________________________. This authorization is in effect until revoked by me.



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Signature of Patient/Insured **Date**

Consent For Use And Disclosure Of Health Information

SECTION A: PATIENT GIVING CONSENT

Patient's Name: ____ Date of Birth : ____________________________

SECTION B: TO THE PATIENT—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, insurance filing and healthcare operations.

[ ] I authorize the release of information including diagnosis, records: examination rendered to me and claims information. This information may be released to:

□ Spouse(Name): ____ Phone: ________________________________

□ Child(ren) (Name):____ Phone: ________________________________

□ Other: ____ Phone: ________________________________

[ ] Information is not to be released to anyone.

Messages:

Please call: □ My Home □ My Work □ My Cell Phone: ______________________ □ Spouse: ___________________

If unable to reach me:

□ You may leave a detailed message

□ Leave a message asking me to return your call

This **Release of Information** will remain in effect until termination by me in writing.

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 the **Privacy Officer**.

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.

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 heath 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: ____