

PATIENT INFORMATION

OFFICE USE ONLY

____ INITIAL FOR PROFILE UPDATED

____ INITIAL FOR INSURANCE CARD SCANNED

____ INITIAL FOR INSURANCE UPDATED

Today's Date: _____

Patient's Name: _____

Date of Birth: _____ Social Security Number: _____

Home Phone Number: _____ Cell Phone Number: _____

Do you want to receive text confirmations/communication from us? Yes _____ No _____

Email Address: _____

Do you want to receive Emails from us? Yes _____ No _____

Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Pharmacy: _____

Have you had any recent medical issues/procedures/surgeries? _____

Please give Front Desk a list of any medications you are currently taking.

If patient is under 18 – Please complete the following:

Responsible Parties Name: _____

Resp Parties Date of Birth: _____ Resp Parties Social Security #: _____

Phone Numbers if different than listed above: _____

Address if different than listed above: _____

Insurance Information (If Applicable)

PRIMARY INSURANCE INFORMATION

Insurance Company: _____

Name of Policy Holder: _____

Relationship to Insured: () Self () Spouse () Child

Policy Holder's Date of Birth: _____

Policy Holder's SS#: _____

Policy Holder's Employer: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____

Name of Policy Holder: _____

Relationship to Insured: () Self () Spouse () Child

Policy Holder's Date of Birth: _____

Policy Holder's SS#: _____

Policy Holder's Employer: _____

Please give a copy of your card(s) to the front desk or send a copy of your insurance information, including Employer, Carrier, Policy Number, and Group Number, to kkidd@danvilledentalassociates.com

Patient/Responsible Party Signature

NEW PATIENTS:

How were you referred to us? _____ When was your last cleaning? _____

Who was your last treating dentist? _____

Medical History Form

Patient Name: _____ Emergency Contact _____
Date of Birth: _____ Emergency Contact Phone _____
Sex: _____ Emergency Contact Relationship _____

Do you have any of the following diseases or problems

Active Tuberculosis ☐ Yes ☐ No
Persistent cough greater than a 3 week duration ☐ Yes ☐ No
Cough that produces blood ☐ Yes ☐ No
Been exposed to anyone with tuberculosis ☐ Yes ☐ No

Medical History

Are you now under the care of a physician? ☐ Yes ☐ No
Physician Name _____
Phone (including area code) _____
Address/City/State/Zip _____
Are you in good health? ☐ Yes ☐ No
Has there been any change in your general health within the past year? ☐ Yes ☐ No
If yes, what condition is being treated? _____
Date of last physical exam _____
Have you had a serious illness, operation or been hospitalized in the past 5 years? ☐ Yes ☐ No
If yes, what was the illness or problem? _____
Are you taking or have you recently taken any prescription or over the counter medicine(s)? ☐ Yes ☐ No
If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements

Do you wear contact lenses? ☐ Yes ☐ No
Joint Replacement. Have you had any orthopedic total joint (hip, knee, elbow, finger) replacement? .. ☐ Yes ☐ No
Date _____
If yes, have you had any complications? _____
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? ☐ Yes ☐ No
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous biphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ Yes ☐ No
Date Treatment began _____
Do you use controlled substances (drugs)? ☐ Yes ☐ No
Do you use tobacco (smoking, snuff, chew, bidis)? ☐ Yes ☐ No
If so, are you interested in stopping? VERY / SOMEWHAT / NOT INTERESTED _____
Do you drink alcoholic beverages? ☐ Yes ☐ No
If yes, how much alcohol did you drink in the last 24 hours? _____
If yes, how much do you typically drink in a week? _____

WOMEN ONLY. Are you:

Pregnant ☐ Yes ☐ No
Number of weeks _____
Taking birth control pills or hormonal replacement? ☐ Yes ☐ No
Nursing? ☐ Yes ☐ No

Allergies, Are you allergic to or have you had any reaction to

Local anesthetics	☐ Yes	☐ No	Latex (rubber)	☐ Yes	☐ No
Aspirin	☐ Yes	☐ No	Iodine	☐ Yes	☐ No
Penicillin or other antibiotics	☐ Yes	☐ No	Hay fever/seasonal	☐ Yes	☐ No
Barbiturates, sedatives, or sleeping pills	☐ Yes	☐ No	Animals	☐ Yes	☐ No
Sulfa drugs	☐ Yes	☐ No	Food	☐ Yes	☐ No
Codeine or other narcotics	☐ Yes	☐ No	Other	☐ Yes	☐ No
Metals	☐ Yes	☐ No	If Other, please specify: _____		

Congenital Heart Disease (CHD) - Please indicate if you have had or not had any of the following:

Artificial (prosthetic) heart valve	☐ Yes	☐ No	Unrepaired, cyanotic CHD	☐ Yes	☐ No
Previous infective endocarditis	☐ Yes	☐ No	Repaired (completely) in the last 6 months	☐ Yes	☐ No
Damaged valves in transplanted heart	☐ Yes	☐ No	Repaired CHD with residual defects	☐ Yes	☐ No
Congenital heart disease (CHD)	☐ Yes	☐ No			

Other Diseases and Conditions - Please indicate if you have had or not had any of the following:

Cardiovascular disease	☐ Yes	☐ No	Cancer/Chemotherapy/Radiation Treatment	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Chest pain upon exertion	☐ Yes	☐ No
Arteriosclerosis	☐ Yes	☐ No	Chronic pain	☐ Yes	☐ No
Congestive heart failure	☐ Yes	☐ No	Diabetes Type I or II	☐ Yes	☐ No
Damaged heart valves	☐ Yes	☐ No	Eating disorder	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No	Malnutrition	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No	Gastrointestinal disease	☐ Yes	☐ No
Low blood pressure	☐ Yes	☐ No	G.E. Reflux/persistent heartburn	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	Thyroid problems	☐ Yes	☐ No
Other congenital heart defects	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Mitral valve prolapse	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No	Hepatitis, jaundice or liver disease	☐ Yes	☐ No
Rheumatic fever	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No
Rheumatic heart disease	☐ Yes	☐ No	Fainting spells or seizures	☐ Yes	☐ No
Abnormal bleeding	☐ Yes	☐ No	Neurological disorders	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	If yes, please specify _____		
Blood transfusion	☐ Yes	☐ No	Sleep disorder	☐ Yes	☐ No
If yes, date _____			Mental health disorders	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No	Specify _____		
AIDS or HIV	☐ Yes	☐ No	Recurrent infections	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Type of infection _____		
Autoimmune disease	☐ Yes	☐ No	Kidney problems	☐ Yes	☐ No
Rheumatoid arthritis	☐ Yes	☐ No	Night sweats	☐ Yes	☐ No
Systemic lupus erythematosus	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Persistent swollen glands in neck	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Severe headaches/migraines	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Severe or rapid weight loss	☐ Yes	☐ No
Sinus trouble	☐ Yes	☐ No	Sexually transmitted disease	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Excessive urination	☐ Yes	☐ No

Premedication

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

☐ Yes

☐ No

Name of physician or dentist making recommendation (include phone number) _____

Do you have any disease, condition, or problem not listed above that you think I should know about?

☐ Yes

☐ No

Please explain _____

Signature of Patient/Legal Guardian

THIS NOTICE DESCRIBES TO WHOM MEDICAL INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides privacy protections to your medical records. Our benefits office (or other third party designated by our office) may sometimes need to disclose medical information or payment information protected by HIPAA in relation to our group health plans to your family members or close friends involved in your health care. For example, your spouse may need to contact us if you are in the hospital to determine whether a particular procedure is covered under our group health plan or may need assistance filing a claim for medical services. Under HIPAA, unless you specifically object we are allowed to use our professional judgment in deciding whether to discuss you medical and payment information with you family members or close friends. However, we would like to provide you with the opportunity to tell us with whom we may discuss your medical or payment information under our group health plans.

You may communicate with the following individuals relating to my medical or payment information:

			Type of Information Allowed to Disclose (Check one or both)		Method of Disclosure (Check one or both)	
Name	Relationship	Phone Number	Medical	Billing	Phone	In Person

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the Human Resources office at 770 Piney Forest Road, Danville, Virginia. (434) 799-8825.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I been offered a copy of the HIPAA Consent form.

Patient or Personal Representative Signature (If patient is Minor)

Date

Financial Policy for Patient Care Services

To help provide the most efficient and reasonable health care services, it is necessary for us to have a *Financial Policy* stating requirements for payment of services provided to our patients. Patients are ultimately responsible for the payment of all services provided by our office.

DENTAL INSURANCE AND PATIENT CONSENT:

- As a courtesy, our office will file a claim with your primary insurance carrier on the date of service. We can assist you with secondary coverage. By signing below, you are authorizing our office to submit these claims on your behalf, along with any xrays or treatment information needed for insurance to approve payment of the services. This includes release to hospital or health care service plans, insurance companies, self-insurers, or their representatives, any and all information and records (including x-rays) about my medial history, or about services rendered or treatment given to me that is needed to review, investigate or evaluate any claim for benefits.
- If you have dental insurance, your estimated portion of the charges (deductible or co-pay) is expected at the time of service. There may be finance charges added to your account if we have to bill you for charges that were due on the date of service.
- You are responsible to notify this office if your insurance has changed and provide updated cards at each visit.
- Since we are not a party to the agreement between you and your insurance company, we may ask that you assist us in contacting them in the event that services are not paid within 30 days.
- Insurance claims unpaid after 30 days are the responsibility of the patient.
- If we receive payment from the insurance company and you have already made payment for that date of service, we will prepare a refund for any overpayment and send it to you.

SELF PAY:

- If you do not have dental insurance and you are a "self-pay" patient, we ask that you pay the entire balance at the time of treatment, unless Payment Plan arrangements are made with your doctor and the *Finance Manager*.
- We accept cash, check, and major credit cards, such as *Visa, MasterCard, Discover, and American Express*.
- We also have a flexible payment plan called *CareCredit*, which allows you to start treatment today and spread payments over time. Both plans consist of an Interest Free Option and a low interest Extended Payment Plan Option, when you need more time to pay. Applying for approval only takes a few minutes and there is no fee to apply. Our financial coordinator can assist you in setting up a payment plan with *CareCredit* prior to your appointment.
- We participate in a program known as *Vistas* that can draft monthly payments from your checking account or enter charges on your credit card to save you the hassle of remembering to send a payment. This plan requires doctor approval, a credit check, 50% down payment, interest, statement fees, and the payments set to draft monthly from your checking account.

DISCOUNTS: (only self-paying patients paying the full balance – no discounts given on insurance copays)

- If the account balance is zero prior to entering this date's services:
 - A 10% discount will be given when paying the full balance with cash or check.
 - A 5 % discount will be given when paying the full balance with credit card.
- *CareCredit* payment plans do not qualify for discounts.
- We offer membership in a discount plan through Collinsville Dental that includes discounted check-ups and other dental work. Ask a receptionist for details.

RETURNED CHECKS:

- There is a \$25.00 service charge on all returned checks.

MISSED OR CANCELLED APPOINTMENTS & LATE ARRIVALS:

- Missed appointments, cancellations and late arrivals are a tremendous loss for a practice. Please help our office reduce those losses by canceling with at least 24 hours notice if you cannot keep your appointment.
- Failure to give notice 24 hours prior to your appointment may result in a \$66 fee to be paid by the patient or the account being locked for up to 120 days.
- Late arrivals of more than 5-10 minutes may result in rescheduling the appointment to another day.

DELINQUENT ACCOUNTS:

- Financial arrangements and regular payments must be made for balances carried on account by our office. Allowing an account to become seriously past due will result in being turned over to a credit bureau, collection agency and/or the court system. The responsible party will also be required to pay all attorney's fees and other collection fees associated with this type of action. By your signature below, you understand that the contact information that you provide to the office will be used to contact you if needed for any delinquent account communication.

PATIENT INFORMATION:

- Patients are responsible for updating Collinsville Dental Associates with current information (including name, address, phone, medical/health, employer, and insurance) for themselves, their family members and their insurance. By signing below, I **acknowledge that payment is due at the time of treatment**, unless prior arrangements have been made with the Doctor and Finance Manager before the appointment. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. If I am insured, I understand that I am financially responsible for all charges whether or not they are covered by insurance.