Chart#: ____________ FOR OFFICE USE ONLY

Patient Information

Patient Name: ______________________________ Date: __________
Last First MI (Preferred Name)

Gender(M/F):_____ Marital Status:__________ Birth Date:__________ Social Security #:__________

Driver's License #:__________ E-Mail Address:__________

Address: ______________________________
Street Apartment #

____
City State Zip Code

Phone #'s: Home __________ Work __________ Ext __________ Best time to call:__________

FAX __________ Pager __________ Other __________

Referral Information

Name of person, office or other source referring you to our practice:

____

Spouse or Responsible Party Information

Name: ______________________________ Date: __________
Last First MI (Preferred Name)

Gender(M/F):_____ Marital Status:__________ Birth Date:__________ Social Security #:__________

Driver's License #:__________ E-Mail Address:__________

Address: ______________________________
Street Apartment #

____
City State Zip Code

Phone #'s: Home __________ Work __________ Ext __________ Best time to call:__________

FAX __________ Pager __________ Other __________

Employment Information

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

Employer Name: ______________________________

Address: ______________________________
Street City State Zip Code Phone

Insurance Information

Primary
Name of Insured: ______________________________
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: ______________________________
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: ______________________________

____

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Other Information

Date of Last Dental Visit: ____________

Does Your Medical History Include Any Of The Following? Please answer: Yes (Y) or No (N)

Heart Disease or Heart Problems ____________

Heart Murmur ____________

High Blood Pressure ____________

Diabetes ____________

Asthma ____________

HIV or AIDS ____________

Kidney or Liver Disease ____________

Cancer ____________

Artificial Joints ____________

Epilepsy ____________

Rheumatic Fever ____________

Stroke ____________

Tuberculosis ____________

Hepatitis ____________

Osteoporosis ____________

Respiratory Problems ____________

Excessive Bleeding or Clotting Problems ____________

Smoker? How much? ____________

Pregnant or Nursing ____________

Allergies/Hayfever/Sinus Problems ____________

Allergies to any drugs or medecines? Please List ________________________________

Admitted to a hospital or needed emergency care within the past year? Explain

____

Reason for Dental Visit ____________________

Are your teeth sensitive to hot or cold ________

Are your teeth sensitive to sweets or when chewing? ________

Do your gums bleed? ________

Are you conscious of bad breath or a bad taste? ________

Do you clench or grind your teeth? ________

Does your jaw make clicking or popping noises? ________

Do you have pain in your jaw or near your ears? ________

Have you had previous periodontal treatment (gum specialist) ? ________

Have you ever had trauma/injury to the mouth or face? ________

Please list any medications you are currently taking ____________________

Physician Name ____________________

Physician Phone ____________________

In Case Of Emergency, Notify: ____________________

Phone ____________________

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. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient (or Guardian) Signature ____________________

Date ____________________

CONSENT FOR TREATMENT

1. I hereby authorize Doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed necessary to make a thorough diagnosis of (name of patient) ____________________'s dental needs.

2. Upon such diagnosis, I authorize the Doctor and/or hygienist to perform all recommended treatment mutually agreed upon by me and to employ such assistance required to provide proper care.

3. I agree to the use of anesthetics sedatives and other medications necessary. I fully understand that the use of said agents imposes certain risks and realize that it is necessary to inform the doctor and staff of any drugs, including recreational drugs that I may be taking in order to minimize these risks.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service, unless other arrangements have been made in advance. I further understand that although I may have dental insurance and The Dental Team will complete any insurance forms as a courtesy, the ultimate responsibility for collection of any money due from my insurance company is mine. In the event that payments are not received by the agreed upon dates, I understand that a 1.5% late charge (18% APR) will be added to my account. In addition to the amount owed, I agree to pay 30% of the unpaid balance if my account is turned over to a collection agency or attorney in an effect to collect any outstanding balance. This may include, but is not limited to, filing fees, court costs, collection agency fees and attorney fees.

Patient Name: ________________________________**Date:**___________________

Patient Signature (Parent or Guardian if patient is a minor):

____

Relationship to Patient: ____

Witness: ____

The Dental Team, Ltd
Financial Policy

Thank you for choosing our practice. This agreement is provided to you to clarify our payment policies. Please read it, ask any questions you may have and sign in the space provided. Our receptionist will provide you with a copy at your request.

Insurance. We participate in all indemnity insurance plans, most PPO plans, some HMO plans and some discount plans. *Knowledge of your insurance benefits is __your__ responsibility.* Please contact your insurance company with any questions you may have regarding your coverage.

Co-Payments and deductibles. All co-payments, co-insurance and/or deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, co-insurance and/or deductibles from patients may be considered insurance fraud. Our office accepts Visa, Mastercard, American Express and Discover Card as well as cash, checks and money orders.

Non-covered services. Please be aware that certain procedures may not be covered by insurance. **If services are not covered by your insurance or if you do not have insurance, payment is expected at time of service unless payment arrangements were made in advance.** Please be advised that we have several methods of payment plans.

Proof of insurance. We will ask to make a copy of your insurance card and ask that you complete our patient information forms before being seen by a doctor or hygienist. We may ask for a photo identification to verify who you are.

Claims of submission. We will submit your claims for you to your insurance company and we will, within reason, attempt to help you get your insurance claims paid. Your insurance company may need you to supply certain information directly. **It is your responsibility to comply with their request.**

Coverage changes. Insurance companies have very strict requirements with regard to filing deadlines for reimbursement of claims. **Please notify us immediately of any insurance changes.** If your insurance company does not pay your claim in 45 days, the balance will be automatically billed to you and payment expected within 10 days of that billing.

Missed appointments. If you are unable to keep your appointment, please notify our office 24 hours in advance. Failure to do so deprives other patients the opportunity to be seen and will result in a charge for broken appointment.

Late payments. An interest charge of 1.5% per month is assessed to all accounts that are past due. Failure to pay your bill within 90 days will result in your account being turned over to a collection agency and reporting to the credit bureaus. There will be a $45 fee for any NSF check.

I have read and understand the financial policy and agree to abide by its guidelines. I understand that, if head of household, it covers the entire household. You give us permission to check your credit and employment history and to answer questions about your credit history with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

______________________________ ____________________

Patient or Guardian Name (Printed) **Date**

____

Patient or Guardian Signature

THE DENTAL TEAM

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________, have received a copy of the Notice of Privacy Practices of this office.

____
Name (Please Print)

______________________________ ____________________
Signature Date

Please Note: It is your right to refuse to sign this acknowledgement.

Office Use Only

We attempted to obtain written acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- o The individual was unwilling to sign.
- o An emergency prevented us from obtaining acknowledgement.
- o A communication barrier prevented us from obtaining acknowledgement.
- o Other (Please Specify):

____
____
____

DENTAL NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1196 (HIPPA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example would be sending a bill to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a copy of this notice form us upon receipt.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may require a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to
file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPPA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257 or Toll Free: (877) 696-6775