AceCare Dental

1 Patient Information

Today's Date ____________

First Name ______________________ MI ______

Last Name ______________________________

Birthdate __________ Age ____ SS# ______________

☐ Married ☐ Single ☐ Widowed ☐ Divorce ☐ Separated

Address ______________________________

____

Home # ______________ Cell # ______________

Employer ______________ Work # ______________

Occupation ______________________________

Email ______________________________

Referred by ______________________________

2 Responsible Party

First Name ______________________ MI ______

Last Name ______________________ ☐ M ☐ F

Birthdate __________ Age ____ SS# ______________

Employer ______________ Work# ______________

Occupation ______________________________

Employer's Address ______________________________

____

3 Primary Dental Insurance

Insurance Co. Name ______________________________

Insurance Co. Address ______________________________

Insurance Co. Phone ______________________________

Plan __________ Group __________ Policy __________

Policy Owners Name ______________________________

Relationship to Patient ______________________________

Policy Owners Birthdate __________ SS# ______________

Policy Owners Employer ______________________________

Employees Address ______________________________

Orthodontic Coverage? ☐ Yes ☐ No

4 Secondary Dental Insurance

Insurance Co. Name ______________________________

Insurance Co. Address ______________________________

Insurance Co. Phone ______________________________

Plan __________ Group __________ Policy

Policy Owners Name ______________________________

Relationship to Patient ______________________________

Policy Owners Birthdate __________ SS# ______________

Policy Owners Employer ______________________________

Employees Address ______________________________

Orthodontic Coverage? ☐ Yes ☐ No

5 Dental History

Purpose of todays visit ______________________________

Previous dentist ______________________________

When was your last visit ______________________________

What was done ______________________________

Last Cleaning ______________________________

How often do you brush ________ Gums bleed ☐ Yes ☐ No

Any ☐ Sensitive teeth ☐ Loose teeth ☐ Broken Fillings ☐ Jaw pain ☐ Injuries to teeth

Explain ______________________________

Unpleasant Dental Experience ☐ Yes ☐ No

Explain ______________________________

Have you ever had ☐ Orthodontics ☐ Gum Treatment ☐ Root Canal ☐ Oral Surgery ☐ Crowns ☐ Veneers ☐ Implants

Are you happy with the appearance of your teeth?

☐ Yes ☐ No ☐ Color ☐ Position ☐ Smile

Have you ever had tooth whitening? ☐ Yes ☐ No

☐ In Office ☐ Overnight ☐ Drug Store

Are you interested in replacing any missing teeth? ☐ Yes ☐ No

Which method ☐ With Dentures ☐ Bridges ☐ Implants

Do you have any questions for the doctor? ☐ Yes ☐ No

(please continue on back)

I authorize the doctor to perform all recommended treatment agreed upon by me and to use the appropriate medication and therapy for such treatment in connection with ______________________ , ____ . I understand that using anesthetic agents embodies a certain risk.
(NAME OF PATIENT).
Furthermore, I authorize and give consent to the doctor to use and employ such assistant as deemed fit to provide recommended treatment.

6 Medical History

Physicians Name ______________________

Office Address ______________________

Telephone ______________________

Are you currently under the care of a physician? ☐ Yes ☐ No

Explain ______________________

Has there been a recent change to your health? ☐ Yes ☐ No

Explain ______________________

Are you currently taken any prescription, over the counter of recreational drugs? ☐ Yes ☐ No

Explain ______________________

Have you been hospitalized or had a serious illness within the past five years? ☐ Yes ☐ No

Explain ______________________

Please mark any allergies/adverse reactions:

Y N Penicillin
Y N Tetracycline
Y N Erythromycin
Y N Sulfa
Y N Local Anesthetics
Y N Codeine
Y N NSAID (Advil/Motrin)
Y N Aspirin
Y N Valium
Y N Barbiturates
Y N Latex
Y N Iodine
Y N Household Bleach
Other ______________

Do you?

☐ Smoke Packs Per Day? ________ How Long? ________
☐ Chew Tobacco
☐ Drink Per Week? ________ Per Month? ________
☐ Wear Contact Lenses

☐ Take Diet Pills ☐ Take Herbal Supplements

Check if you have or ever had

Y N Artificial Limb/joint/hip
Y N High/low Blood Pressure
Y N Organ Transplant
Y N Sinus Problems
Y N Migraines
Y N Frequent Headaches
Y N Claustrophobia
Y N Artificial Heart Valve
Y N Prolonged Bleeding
Y N Ulcers/colitis
Y N Hay Fever
Y N Head Injury
Y N Venereal Disease
Y N Mitral Valve Prolapse
Y N Anemia
Y N Acid Reflux
Y N Arthritis
Y N Epilepsy/seizures
Y N STD
Y N Rheumatic Fever
Y N Radiation Therapy
Y N Stomach Problems
Y N Glaucoma
Y N Dizziness/Fainting Spells
Y N Treated For AIDS, HIV, ARC
Y N Heart Murmur
Y N Thyroid Problems
Y N Used Phen Phen
Y N Chronic Diarrhea
Y N Stroke TIA
Y N Joint Surgery
Y N Cancer/chemotherapy
Y N Blood Disorder
Y N Increased Frequent Urination
Y N Bells Palsy
Y N Heart Disease
Y N Diabetes
Y N Asthma
Y N Night Sweats
Y N Psychiatric Or Emotional
Y N Recurrent Infections
Y N Angina
Y N Kidney Problems
Y N Bronchitis
Y N Addictions
Y N Pace Maker
Y N Liver Problems
Y N Emphysema
Y N TMJ Problems
Y N Shortness Of Breath
Y N Hepatitis: A or B or C
Y N Tuberculosis
Y N Unexplained Weight Loss
Y N Mouth Ulcers

7 Office Policy

We reserve the right to charge for any cancelled appointments if we do not receive 48 hours notice. All accounts sent to collections will be charged the account balance plus an additional 50% based on the account balance. Regardless of insurance, patients are fully responsible for any account balance. Patients are encouraged to ask all relevant dental & medical questions and thus fully understand the cost, time, limitations, and potential complications of any dental care they agree to receive. The dental profession can not be responsible for any treatment failures that are the result of patient neglect, injury or abuse. By my signature I hereby do certify that: I have read and understood the office policy. All information I have provided is accurate. I will update the office regarding any changes in this information. I will not hold any member of the dental staff responsible for actions resulting from any errors or omissions that I have made in the completion of this form. *Note: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.* I certify that I have read and understand the above. I acknowledge that my questions, if any, have been answered to my satisfaction. I will not hold my dentist, or any other member of his or her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Our Legal Duty: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 04/14/2003 and will remain in effect until we replace it.

Accept Assignment: My signature authorizes the release of necessary information needed to process my claim, and to pay benefits to the provider of service.

______________________ SIGNATURE OF PARENT OR GUARDIAN ________ DATE

8 For Completion By Dentist

Comments on patient interview concerning health history

____

____

____

Significant findings from questionnaire or oral interview

____

____

____

Dental Management considerations

____

____

______________________ SIGNATURE OF DENTIST ________ DATE

USE AND DISCLOSURE AUTHORIZATION

SECTION 1: Please complete the following for all requests

1) Today's Date:____________________________

2) Patient's Name:______________________________________

SECTION 2: I hereby request the following regarding the use of my Personal Health Information:

You may discuss information regarding my treatment and care with the following family members/or friends:

NAME	RELATIONSHIP

____

SIGNATURE OF PATIENT OR GUARDIAN

DATE____

Patient Acknowledgment of Receipt of Notice of Privacy Practices

Please Print

I, ______________________________, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact:

____

____

____

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative

Signature: ______________________________ Date: ___/___/___

Name: ______________________________
Please Print

Relationship to Patient: ______________________________

For Office Use Only

We made a good-faith effort to obtain an acknowledgment of ______________________________'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

- ☐ Patient refused to sign (date of refusal) ___/___/___.
- ☐ Communications barriers prohibited obtaining an acknowledgment.
- ☐ An emergency situation prevented us from obtaining an acknowledgment.
- ☐ Other ______________________________

Attempt was made by: ______________________________ Date: ___/___/___

This product is designed to provide accurate and authoritative information. However, it is not a substitute for legal advice and does not provide legal opinions on any specific facts or services. The information is provided with the understanding that any person or entity involved in creating, producing or distributing this product is not liable for any damages arising out of the use or inability to use this product. You are urged to consult an attorney concerning your particular situation and any specific questions or concerns you may have.

Important note: This is approved for use by the purchaser only. This form may not be shared publicly or with third parties.

COMPLYRIGHT™

A1354 ©2013 ComplyRight

ATTORNEY APPROVED

Patient Consent & Authorization for Release of Protected Health Information

Please Print

Patient Name: X_______________________________ Date of Birth: ______________

Address: ____

City: ______________________ State: _____ ZIP Code: ___________ Telephone Number: ______________

E-mail Address: ____

Patient Authorization

I, ______________________________, hereby authorize the release, use or disclosure of my health information as follows:

This authorization pertains to the following type of medical information about me:

____

____

I hereby authorize **Acecare Dental**

to release the above-described information to ______________________________________.

Name of individual(s) and/or organization receiving this information

I understand that, per my request, this authorization will permit the above-named parties to use or disclose the identified health information for purposes beyond treatment, payment, or healthcare operations as provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that I may revoke this authorization at any time by providing written notification to:

______________________________________.

The revocation will be effective on the date it has been received and processed by the above-named recipient. I understand that the revocation does not apply to actions taken in reliance upon this authorization prior to the effective date of revocation. I also understand that I do not have to sign this authorization in order to receive treatment, payment, or to enroll or be eligible for benefits.

Unless I request in writing otherwise, I understand that this authorization will expire on ______________________ (Expiration date or event). If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date on which I signed this authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the named recipient, and may no longer be protected by HIPAA's privacy rules after the authorized disclosure.

Patient or Personal Representative

Signature: ______________________________ Date: ___/___/___

Name: ______________________________

Please Print

Relationship to Patient: ______________________________

For Office Use Only

Received by: ______________________________ Date: ___/___/___

This product is designed to provide accurate and authoritative information. However, it is not a substitute for legal advice and does not provide legal opinions on any specific facts or services. The information is provided with the understanding that any person or entity involved in creating, producing or distributing this product is not liable for any damages arising out of the use or inability to use this product. You are urged to consult an attorney concerning your particular situation and any specific questions or concerns you may have.

Important note: This is approved for use by the purchaser only. This form may not be shared publicly or with third parties.

COMPLYRIGHT™

A1350 ©2013 ComplyRight

ATTORNEY APPROVED

Financial Policy

The doctors and staff of AceCare Dental would like to welcome you to our practice. We strive to provide you with excellent medical care and our goal is to make your visit as convenient as possible.

We ask for your help by understanding and cooperating with our financial policy.

Please read this policy and sign below confirming you understand the following.

- All payments-Self pay fees, Insurance co-payments, co-insurance, and deductible will be collected at the time of service. Payable by cash, check, Visa, MasterCard, Discover or American express. Your account is to be kept current.
- A return check will result in a $25 service charge <u>and</u> all future payments being required in the form of cash or Credit Card.
- If you do not have your payment(s), your appointment may be rescheduled.
- Payment in full of any past due balance is expected prior to being seen in our office.
- Refunds will be issued within 6 weeks from date requested, if there is no pending insurance claim.
- There is a $25 charge for completion of paperwork (ex: disability, FMLA etc.) Paperwork may take up to 7-14 days of completion.
- Any balance over 90 days old will be processed and sent to a collection agency.
- Our practice participates with several insurance companies; it is your responsibility to understand the requirements and covered benefits or your plan.
- You are responsible for any non-covered and/ or denied claim; you will receive a statement or denied charges and payment is due in 30 days after date of statement.
- If your insurance policy requires a referral, it is your responsibility to contact your primary care physician and have a referral faxed to our office prior to your appointment date.
- It is your responsibility to notify our office of any changes to your insurance coverage, your address and telephone number.
- You are required to cancel appointment 24 hours prior to appointment time to avoid $25 cancellation charge for Doctor and $100 for Procedure/ Facility.

We realize that temporary financial problems may affect timely payment of accounts. If such problems arise, we urge you to contact us promptly for assistance in the management of your account. Contact our professional staff for assistance in the management of your account. Contact our professional staff in the Business Office; we are here to help you with any questions and issues. Call 407-542-7888

I have read and understand the above Financial Policy and agree to meet all financial obligations.

Patient Name (print)	Patient Signature	Date