PATIENT INFORMATION (CONFIDENTIAL)

Date _____

Name _____ Sex: ☐M ☐F Soc. Sec # _____

Preferred Name _____ Birth date _____

Address _____ City _____ State _____ Zip_____

Home Phone _____ Cell Phone _____ Best Contact Number ☐ Home ☐ Cell ☐ Work

Email Address _____ ☐ Receive Email Correspondence ☐ Receive Text Notifications

Check Appropriate Box: ☐Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or Parent's Employer_____ Work Phone _____

Spouse or Parent's Name _____ Cell Phone _____

Employer _____ Work Phone _____

Referred by: ☐TV ☐ Radio ☐ Phone Book ☐ Flyer ☐Friend\Family _____
☐ Other (specify) _____

Person to Contact in Case of Emergency _____ Phone _____

RESPONSIBLE PARTY

Name of Person Responsible for this account _____ Relationship to Patient _____

Address _____ Home Phone _____

Birth date _____ Cell Phone _____

Employer _____ Work Phone _____ Soc Sec # _____

Is this person currently a patient in our office? ☐Yes ☐No

DENTAL INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Birth date _____ Soc Sec # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Policy Holder _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy\ID # _____

Ins Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max Annual Benefit? _____

Our goal is to learn more about you so our dental team can supply you with all the important information you will need to make an informed decision regarding your dental health.

What are your objectives regarding your dental health?

☐ Pain free ☐ Bright white smile ☐ Healthy gums ☐ Straighter teeth

☐ Keeping your natural teeth for a lifetime ☐ Fresh breath

☐ Handle the problem correctly the first time

Other_____

What dental problems have you had in the past? Currently experiencing? How do these problems affect you?

Do you ever experience headaches, neck or back pain? ☐ Yes ☐ No

So that we may serve you personally and comfortably, which of the following are most important to you?

_____ On time from start to finish

_____ Ideal appointment times _____ day's _____.

_____ A clear understanding of problem and recommended solutions

_____ To know absolutely everything that is going on in your mouth, regardless of its severity

_____ To handle only your most pressing needs

_____ To be informed of how to enhance your:

Facial appearance _____ The whiteness of your teeth _____ Your overall health _____

_____ To be called after your visit to see how you are doing

_____ To be done with treatment sooner with longer appointments

_____ Multiple shorter appointments to complete treatment

_____ A call to remind you of the exact time of your appointment so you can be prompt

We are a zero-balance office. If there is an investment in your health, what method of payment is best for you?

☐ Cash ☐ Check ☐ Credit Card ☐ Financing

What expectations do you have of us?

Do you have any questions you would like to discuss?

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION (HIPAA)

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.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices.

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

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.

PRINT NAME: _____

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: _____

ACCEPTING INSURANCE ASSIGNMENT AGREEMENT

Our office is pleased to accept your insurance assignment. We offer this service as a courtesy to our patients. However, it must be clearly understood that the "CONTRACT" is between the patient and the insurance company, the account thereby being the responsibility of the patient for any amount not paid by the insurance company. Below are statements of our policies governing insurance claims:

1. With the exception of Delta Dental Insurance, our office does bill the insurance company. Therefore it is necessary for the patient to have all of the insurance information filled out completely. If this is not completed, we will not be able to appropriately bill the insurance company, and the responsibility for payment then becomes that of the patient. There are no exceptions to this agreement.
2. The patient will pay the co-payment (the amount not covered by the insurance company) and applicable deductible as agreed upon during the financial consultation is **DUE ON DATE OF SERVICE**. The insurance company will never guarantee payment – they only give us an estimated fee amount. **The patient's portion may be more than the estimate given to us by the insurance company.**
3. Insurance payments ordinarily are received within 30 to 60 days from the time of billing. **If a patients' insurance company has not made a payment to our office within 60 days,** we may request that the patient pay the balance due, and then seek reimbursement from the insurance company when and if it pays.
4. Our office does NOT guarantee that the patient's insurance company will pay. We will perform our routine insurance billing procedures upon verification of coverage. However, if for some reason, the patient's insurance claim is denied, the patient is then considered to be responsible in full for the amount of the bill.
5. Our office will not enter into a "dispute" with an insurance company over any claim. Although we will work with the insurance company to sort out any confusions or questions which might arise. We cooperate fully with the regulations and requests of the insurance companies. It will be, however, the responsibility of the patient to handle with the insurance company any type of dispute over payment by the company.

If you understand and agree with all of the above practice policies, please sign your name below and we will accept your insurance assignment.

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: _____

PAYMENT ARRANGEMENT

Thank you for choosing Lifetime Dental Care as your dental health care provider. We are committed to the success of your dental treatment and want to provide you with the best service available. To help reduce administrative costs and keep our fees as low as possible, we respectfully request payment to be made at the time that you or your family members receive treatment. Please indicate below the method of payment you intend to use.

My preferred payment option is:

_____ Cash/check

_____ Major credit card (Visa, MasterCard or Discover)

_____ For treatment amounts over $300.00 please inquire about the possibility of an extended payment plan through Care Credit or visit www.carecredit.com

Signature: _____ **Date: _____**

Lifetime Dental Care staff members will always recommend the highest standard of treatment. Our primary concern is your overall health. If you wish, we will gladly discuss alternative treatments or phases to work within your financial budget. We recognize that every patient will have different situations and, ultimately, it is up to you to decide the importance of your dental health and whether you wish to accept the recommended treatment. If you have any questions regarding these policies or financial arrangements, please contact our financial coordinator about your concerns.

APPOINTMENT CANCELLATION AGREEMENT

I, _____ understand that it is my responsibility to kindly call and cancel or reschedule any appointment. I will do so **48 hours** prior to my scheduled appointment, or I will leave a message on the office answering machine if the office is closed.

If an appointment is missed without calling in to cancel or reschedule I agree to pay a no show fee of $75.00 for a missed oral wellness visit or $150.00 for a missed restorative appointment. This fee will be billed accordingly and is not covered by insurance. If three appointments are missed without appropriate notice, this office will no longer be able to reschedule you for further appointments.

I have read and understand my obligation as a patient/parent/patient representative to this office in regards to Lifetime Dental Care's appointment cancellation policy.

SIGNATURE: _____ Date: _____