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.

✍ ➲

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: _____

Appointment Cancellation Policy

We strive to provide excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel or reschedule an appointment, you may be preventing another patient from getting much needed treatment. **If an appointment is not cancelled or rescheduled with a 24-hour notice, you will be charged a $ 25.00 fee.**

Our policy is as follows:

(please initial the following)

_____ We require that you give our office 24 hours' notice in the event that you need to reschedule your appointment.

_____ If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of **$ 25.00** will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled with out payment of this fee.

_____ Appointments must be confirmed within 24 hours of the appointment time by responding to our confirmation call, text or email. If you do not confirm your appointment, we reserve the right to cancel your appointment and give it to another patient.

_____ We understand that delays can happen, however, we must try to keep the other patients and providers on time. If a patient is more than 10 minutes late to their scheduled appointment, we reserve the right to reschedule the appointment to another day and will consider this a missed appointment and the $ 25.00 cancellation fee will be charged.

_____ When a patient repeatedly misses scheduled appointments, it becomes an inconvenience to the practice. Therefore, at the discretion of the doctor, if a patient misses three consecutive appointments without proper notification, he or she may be subject to dismissal from our practice. A letter will be sent to the patient informing him or her of the decision and/or process.

Note: Parents bringing in two or more family members at the same time will be restricted from scheduling a double or triple appointment after missing two such appointments for multiple family members.

_____ _____

Print Name Date

_____

Signature of Responsible Party

PATIENT RESPONSIBILITY NOTICE WAIVER FORM

Patient Name: _____

Dr. Alison L. Boone provides many different types of dental services including exams, emergency treatment, fillings, crowns, extractions, dentures and partials, periodontal treatment and other procedures in general dentistry. Although insurance companies may cover all or a percentage of most services provided, there are some insurance companies that do not cover certain types of procedures due to waiting periods, limited plan benefits, or frequency of prosthesis replacement.

Our staff makes every effort to assist you in understanding your dental health benefits. However, it is impossible for us to know all of the many different employer group benefits from the thousands of dental plans offered. Therefore, we are providing this notice to inform you of the following responsibilities as they relate to dental insurance benefit coverage and payment.

- Dr. Alison L. Boone, DDS cannot be responsible for knowing what services are covered by your insurance plan and we are not responsible for non-payment or denial for services provided. We treatment plan based on the needs of each individual patient and not to what insurance will or will not cover.

- It is you, the patient that is responsible for knowing and understanding your dental insurance benefit coverages and limitations. You are ultimately responsible for any estimated co-payments for services rendered by Dr. Boone at the time of service and will be responsible for any treatment provided that is not covered by your insurance company.

We are certainly willing to **PRE-AUTHORIZE** any treatment recommended by Dr. Boone with your insurance company but this service must be requested by you and may take up to eight weeks to receive.

By signing below, I hereby acknowledge and understand my responsibilities as a patient of Dr. Boone and accept that Dr. Boone and staff are not responsible for knowing my individual dental insurance benefit coverages for services provided.

_____ _____

Signature of Responsible Party Date