Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work): _____ Ext:_____ (Cellular):_____

E-Mail Address:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Our office confirms thru cellular or email if you do not want any of these services please let the office know.

Health Information

Date of Last Dental Visit: _____ Previous dentist _____Recent x-rays _____

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV
☐ Allergies _____ _____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Diabetes
☐ Cancer
Type_____
☐ Chemotherapy
☐ Biophosphonate
☐ Radiation
☐ Drug Dependency

☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders

☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy**
Due date:_____
☐ Birth control
☐ Prostate Disorder
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease

☐ Codeine Allergy
☐ Metal Allergy
☐ Penicillin Allergy
☐ Latex Allergy
☐ Thyroid
☐ High Cholesterol
☐ Emphysema
OTHER:
_____
Medications:
_____
_____
_____
_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Physician:_____ Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____
- What is your immediate dental concern?_____

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.

_____ Date:_____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other_____

Name of person or office referring you to our practice:_____

Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Cellular: _____

Email address:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

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

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Consent for Services

It's important that we provide you with all the information you need to make your treatment decisions. We are committed to researching your insurance if needed, and discussing your treatment options and financial responsibilities prior to services being rendered. In the case of emergency services, we will update you as soon as possible regarding how your insurance may assist you.

If you have dental insurance, we will research your benefits, and submit your claims to your insurance company for reimbursement. You will only be required to take care of your estimated copayment at the time of your appointment. The remaining balance will be billed to your insurance company. It is our expectation we will be reimbursed by your insurance company within 60 days. If your insurance company does not reimburse as expected within 60 days of the service, you will be expected to take care of the balance in full at that time. We are unable to render services on the assumption that our charges will be paid by an insurance company.

Because your insurance reimbursement is based on a contact between you, your employer, and the insurance company, we are only able to advocate on your behalf. No insurance company will ever guarantee benefits prior to a service being rendered.

Your signature on this form demonstrates your agreement to pay all fees incurred to Doctor Hunsicker, or her assignee, at the time services are rendered, or within five (5) days of billing if credit shall be extended. You agree that the reasonable value of services shall be as billed unless objected to, by you, in writing, within the time for payment requested by the practice.

You are also granting permission to be contacted at home or at my work to discuss matters related to this form.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Financial Policy

We are committed to providing you with the best possible dental care. If you have dental insurance we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Your insurance is a contract between you, your employer and/ or the insurance company. A signed completed form or a copy of your insurance card will be needed at your initial appointment. Without this information we cannot bill your insurance company therefore we will bill you the patient directly. We will be happy to assist you as much as possible in completing your forms. Please be sure to inform us of any changes in your dental coverage at the time of your appointment.

We are a United Concordia, Delta Dental, Fidelio, NCAS, Guardian, Employment Benefit Metlife, Aetna PPO, Blue Cross Dental, Assuarant,United Healthcare, GEHA and selective Cigna plans participating office. We accept most insurance plans.
However please be sure to contact your insurance company to verify that you do not have to see a participating dentist. Not all services are covered benefit in all contracts. **We suggest If you need clarification to call your insurance company.**

Dr. Ann Hunsicker does offer the courtesy of electronically billing the insurance company for you. An authorization for signature on file will need to be signed at your first visit in order to submit electronically. While the filing of insurance claims is a courtesy that we do extend to our patients, **all charges are your responsibility from the date services are rendered**. If Insurance payment is not received with in 45 days patient is responsible for all charges incurred. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account . We request 24 hour notification for cancelled or rescheduled appointments. There will be a $1.00 charge per minute for scheduled appointment time.

I understand and agree that, (regardless of my insurance status). I am ultimately responsible for the balance on my account for any professional services rendered.

Signature_____ Date_____

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I am aware of the *Notice of Privacy Act* description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason