

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:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Metal Allergy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | Due date: _____ | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Growths | <input type="checkbox"/> Birth control | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Prostate Disorder | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever | OTHER: _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatism | Medications: _____ |
| Type _____ | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Problems | _____ |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Problems | _____ |
| <input type="checkbox"/> Biophosphonate | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Radiation | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Tuberculosis | _____ |
| <input type="checkbox"/> Drug Dependency | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tumors | _____ |
| | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcers | |
| | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Venereal Disease | |

- 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.

 Signature of patient, parent or guardian Date: _____

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: _____

X-rays and Photography

I authorize Hellertown Dental Group, the doctor, and team to take any x-rays and photographs deemed necessary for the detection and diagnosis of oral diseases. I authorize the release of this and any other information to my insurance company necessary for processing my dental claim (if applicable and according to HIPAA regulations)

X _____ Date: _____

(Signature of Patient or Responsible Party*) *Responsible Party – Relationship to Patient: _____

HELLERTOWN DENTAL GROUP APPOINTMENT POLICY

COURTESY APPOINTMENT REMINDERS

We do our best to attempt to contact you by either phone, text or email prior to your scheduled appointment. However, these appointment reminders are only a courtesy confirmation, it is your responsibility to remember your appointment.

24 HOUR NOTICE

If you must cancel your dental appointment, please notify our office at least 24 hours in advance. **A 24 hour notice is required to cancel or change an existing appointment.** A cancellation fee may be charged to your account if the appointment is missed, cancelled or rescheduled with less than 24 hours notice. There will be a \$1.00 charge per minute for scheduled appointment time. If missed/cancelled appointments become repeated, any future appointment will require a credit card number to be kept on file and used towards a missed appointment fee.

PAYMENT

Payment is due at the time of service. We gladly accept all major credit cards, checks, cash and money orders. We also accept most insurance plans. **An insurance plan is not a guarantee of payment.** Any quotes given on insurance payments are only an estimate of treatment charges and any fees not paid by the insurance company are your responsibility. Upon acceptance of treatment, the patient/guarantor assumes full financial responsibility for payment on the account. Unless arrangements have been discussed, approved and finalized by our office in advance, treatment is to be paid in full at the time of service. Treatments involving laboratory fees or treatments that require more than one visit to complete (crowns, implants, bridges, dentures etc..) require a down payment when scheduling and a signed financial agreement.

CHILD ADVOCACY:

As an advocate for our young patients, Hellertown Dental Group will not intervene in any case of divorce or separation regarding financial obligations between parents. The parent authorizing treatment for a child will be the parent responsible for those charges. If the divorce decree requires the other parent to pay all or part of treatment costs, it is the responsibility of the authorizing parent to collect payment from the other parent.

I have read and understand Hellertown Dental Group's Appointment Policy and I agree to be bound by its terms. I also understand that such terms may be amended by the practice from time to time.

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Patient Name: _____ Date: _____

Patient/Legal Guardian Signature: _____

CONSENT FOR SERVICES AND FINANCIAL POLICY

Hellertown Dental Group believes that in order to deliver the best quality of dental care possible, it is important to establish and communicate our policies to our patients. It's important that we provide you with all the information you need to make your treatment decisions. In order to do so, we need your assistance and your understanding of our payment policy. **All charges will be your responsibility on the date that services are rendered.** We gladly accept all major credit cards, checks, cash and money orders.

Patients with dental insurance: We accept most insurance plans. Your insurance plan is a contract between you, your employer and/or your insurance company. Not all services are covered benefits in all contracts, benefits vary greatly based on the particular plan. **We cannot guarantee any estimated coverage. Quotes given by our office or the insurance company are only an estimate and do not guarantee any payment.** Regardless of insurance status, the account balance for any services rendered is ultimately the patient/guarantor responsibility. Any of pocket costs including but not limited to deductibles or estimated co-payments will be due at the time of treatment.

It is your responsibility to know your insurance policy rules and benefits. Be sure to contact your insurance company to verify that you do not have to see a participating dentist. If you need any further clarification we suggest you contact your insurance company. We offer the courtesy of electronically billing your insurance company. A copy of your insurance card will be needed to do so. Without this information, we cannot bill your insurance company and therefore we will have to bill you directly. Please be sure to inform us of any changes in your insurance plan at the time of your appointment. **You will be expected to pay for any services rendered if our office is unable to verify your plan by the time of treatment.** If payment for services already rendered has not been received and/or paid in full within 45 business days after treatment, either by yourself or the insurance company, the remaining balance on the account is considered due and will need to be collected.

We are happy to offer an inhouse Hellertown Dental Group Dental Savings Plan to those patients who are uninsured. Please inquire at the front desk for more information on it. In addition, we offer Care Credit- a patient payment program offering a full range of deferred interest. Larger procedures can be broken down into financial arrangements which include a non-refundable down payment at the time the appointment is scheduled. Account balances over 45 days will be subject to a 1.5% late fee charge. Returned checks will be subject to a \$25.00 bounced check fee. This fee is to cover the processing fee that our office is charged when checks are returned.

Your signature on this form demonstrates your agreement to pay all fees incurred to Hellertown Dental Group at the time treatment is provided. By signing below, I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered. I have read, understand and agree to the above terms and conditions. I agree to supply all necessary account information and identification requested by Hellertown Dental Group.

Patient Name: _____

Patient/Guarantor Signature: _____ Date: _____

Notice of Privacy Acknowledgement

Patient Name: _____ Date of Birth: ____/____/____

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy practices or to document our good faith effort to obtain that acknowledgment.

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding you covered under the Privacy Act to people other than yourself.

I _____ authorize Hellertown Dental Group to release information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse _____ DOB _____

Child(ren) _____ DOB _____

Physician _____

Parent _____ DOB _____

Other _____ DOB _____

Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Patient Signature / Legal Guardian Signature if under age Date: _____

Office Use Only:

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but was unable to do so as check below:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)