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: ____

____

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.

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

Patient Name: ____ Date:____________________

Patient/Legal Guardian Signature:____

<u>CONSENT FOR SERVICES AND FINANCIAL POLICY</u>

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 <u>estimate</u> 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. <u>Be sure to contact your insurance company to verify that you do not have to see a participating dentist.</u> 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 Advantage Program (HDGAP) to those patients who are uninsured. Please inquire at the front desk for more information on HDGAP. 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.

____ Date: _________________________

Patient Signature / Legal Guardian Signature if under age

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)