Verified on: ____________Initials: _________

Your Home Family Dentistry

Patient, Insurance, Pharmacy, Financial Policy & HIPAA Information

Patient Information

Prefix: ______ First Name: ___________________ Middle Name: ___________________ Last Name: _________________________

Street: __________________________________ City: ____________________________State: ____________ Zip: ____________

Date of Birth: _________________________ Sex: ☐ Male ☐ Female ☐ Unspecified SSN: _________-_________-_________

Our office utilizes an automated message system to contact our patients for upcoming appointments, reminders, and questionnaires.

Preferred Phone #: _______________________ Is this a mobile number? Yes ☐ No ☐ Email: ______________________________

Emergency Contact

Emergency Contact: ________________________________ Emergency Phone: ______________________ Relationship: ___________________

Preferred Pharmacy

Name: _________________________________ Phone Number: ____________________________

Street: _________________________________ City: ___________________ State: _________________ Zip: ______________

Responsible Party (Please fill out if other than the patient)

First Name: ___________________ Middle Name: ___________________ Last Name: ____________________________________

Street: ______________________________ Zip: ____________ City: ______________________ State: ____________

Date of Birth: _____________Sex: ☐ Male ☐ Female ☐ Unspecified Is This Patient a Minor? Yes ☐ No ☐ SSN: ______-_____-____

Responsible Party Signature: ____ Relationship to Patient: ______________________

Primary Dental Insurance

Is subscriber the same as patient? ☐ Yes ☐ No

First Name: _________________________Last Name: ______________________________ Employer Name: _______________________

Insurance Company: ____Insurance Phone Number: ____________________________

Subscriber ID/Policy Number: ________________________ Group/Contract Number: _______________________________

Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Disabled Dependent ☐ Other: ______________________

Health History

Are you under the care of a primary physician? ☐ Yes ☐ No Primary Physician's Name: ______________________________________

Physician's Phone Number: ______________________Date of Last Visit: _________________ ☐ Greater than 4 years ☐ I do not know

Are you taking or have you taken any steroid/cortisone therapy in the last 2 years? ☐ Yes ☐ No If Yes, Explain: ____________________

______________________________Are you taking, or have you taken Oral Bisphosphonates (e.g., FOSAMAX, BONIVA) or IV Bisphosphonates, (e.g., ZOMETA, AREDIA)? ☐ Yes ☐ No How Long? _______________________________ Have you ever been hospitalized? ☐ Yes ☐ No Please List Specifics:____

____

Do you require antibiotics prior to dental procedures? ☐ Yes ☐ No

Please List Prescribing Physician: ___________________________List Reason for Pre-Med Antibiotics: ___________________________

Prescription Prescribed: _________________________________ Last Date Prescription Filled: __________________________________

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Health History Continued

Are you allergic or have had an adverse reaction to any of the following? ☐ None ☐ Amoxicillin ☐ Aspirin ☐ Codeine ☐ Epinephrine ☐ Latex ☐ Metals ☐ Novocain ☐ Penicillin ☐ Sulfa ☐ Tetracycline ☐ Other: ____

Please list any medications you are taking including non-prescription drugs and herbals/vitamins: ☐ None ☐ Yes

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Check any conditions that apply to you:

- ☐ Alcoholism/Drug Use/Addiction
- ☐ Allergies or Hives
- ☐ Artificial Heart Valve
- ☐ Anemia
- ☐ Artificial Joint/Pins
- ☐ Type: _________________
- Date: _________________
- ☐ Asthma
- ☐ Blood Thinners
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Cancer
- ☐ Type: _________________
- ☐ Chemotherapy
- ☐ Coumadin Therapy
- ☐ Dementia
- ☐ Diabetes
- Type: _________________
- ☐ Dialysis
- ☐ Excessive Bleeding
- ☐ Fainting/Dizziness
- ☐ Heart Murmur
- ☐ Heart Surgery
- Date: _________________
- ☐ Heart Attack/CHF/Issues
- ☐ Type: _________________
- ☐ Hepatitis
- Type: _________________
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Kidney Disease/Dialysis
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease/COPD/Asthma
- ☐ Lupus
- ☐ Mobility Impairment
- ☐ NON-DENTAL Implants
- ☐ Type: _______________
- ☐ Organ Transplants
- ☐ Type: _________________
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Therapy
- ☐ Date: ________________
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sexually Transmitted Diseases
- ☐ Sinus Issues/Problem
- ☐ Smoke/Tobacco/Chew/Vape
- ☐ Stroke
- ☐ Thyroid
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Visual Impairments
- ☐ Other Diseases/Illness
- ☐ Type: _________________

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Female Patients:

Could You Be Pregnant: ☐ Yes ☐ No Are you currently pregnant? ☐ Yes ☐ No If Yes, Estimated Delivery Date: ______________

Are you currently nursing? ☐ Yes ☐ No Are you currently using contraceptives? ☐ Yes ☐ No If yes, List: ____________________

***NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Please consult your physician/gynecologist for assistance regarding additional information. ***

Oral/Dental Health History

Reason for Visit: ☐ Check-up ☐ X-Rays ☐ Tooth Pain ☐ Broken Tooth: Date of Last Dental Visit: _____/_____/_______

☐ I do not know exact date ☐ Last 6 months ☐ 6 months- 1 years ☐ 1-3 years ☐ Greater than 4 years ☐ Never ☐ Other: ________

Previous Dentist: ______________________________________ Referred By: ____

Have you ever been treated for periodontal disease: ☐ Yes ☐ No Have you ever had Novocain/other local anesthetics: ☐ Yes ☐ No

Verified on: ____________Initials: _________

Oral/Dental Health History Continued

How happy are you with your smile (1-10)? ________ Are you currently wearing any type of denture/partial: ☐ Yes ☐ No

Age of dentures/partials: ☐ Less than 6 months ☐ 6 months – 3 years ☐ Greater than 4 years

Please check any conditions that apply to you below:

☐ Pain in Jaw (TMJ) ☐ Teeth Grinding/Clenching ☐ Use of Tobacco Chewing Products ☐ Mouth Sores ☐ Sensitive Teeth ☐ Swollen Gums ☐ Bleeding Gums ☐ Broken/Loose Teeth ☐ Difficultly Chewing/Swallowing ☐ Salivary/Lymph Gland Concerns

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I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to perform an examination and diagnose my condition. I also give my consent for any preventive or basic restorative procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Patient/Guardian's Signature: ____ **Date:** ______________

Dr's Signature/Medical History Review: ______________________________**Date:** ______________

I hereby authorize that the office of Your Home Family Dentistry to leave messages on my voicemail/texts to inform myself of appointments and/or treatment ☐ Yes ☐ No

HIPAA Authorization for Release of Health Records to External Parties (Optional)

☐ I do **NOT** authorize the disclosure of any information from my treatment records

☐ I authorize the disclosure of information from my treatment records to:

Name of 1st Recipient: ______________________________Relationship to the Patient: ______________________________

Name of 2nd Recipient: ______________________________Relationship to the Patient: ______________________________

I give authorization to disclose the following information

☐ **ALL** treatment information

☐ Information related to these treatment dates

Starting Date: ________________________ End Date: _____________________

Financial Policies

Since you are a valued patient and person in our dental practice, we wanted to have a sincere and honest explanation for our financial and insurance policies. We believe in order to give the best possible care to our patients we needed to inform you have the following information. We ask that you read and fully understand the information below. We encourage you to discuss any question you may have. These polices are effective immediately. Thank you for your trust in us. Please Initial: ___________

Payment Policy

Payment in full is required at the time each service is completed. We accept cash, checks, money orders, Visa, MasterCard, American Express and Discover. If necessary, we can help you arrange for financing through CareCredit. There will be a $25.00 charge for returned checks.

INSURANCE/ THIRD PARTY CARRIERS

Insurance companies offer a variety of policies, difference coverages, deductibles, limitations and clauses depending on your specific contract. It is your responsibility to check and update this information with our office.

We will submit your claim on your behalf for any PPO plan, providing you give us all the information we need. Your insurance company will reimburse you/us directly based on your network benefits. Please Initial: ___________

Verified on: ____________Initials: _________

Financial Policies Continued

Attention Delta Dental Patients: Delta Dental updated some of their procedures. Delta will be paying the portion covered by your individual policy to **YOU** directly. This change will require us to collect the fee in full at the time of service. If your insurance needs additional information, it is your responsibility to provide us with the Explanation of Benefits (EOB) provided to you in 14 days after receiving it. Please Initial: ___________

Your insurance policy is a contract between you and your insurance company. **We cannot guarantee payment of claims**. Reduction or rejection of your claim by your insurance does not relieve you of the financial obligation you have to us. The patient is responsible for payment (in full) of their dental care within 60 days of treatment—regardless of the status of the claim. Your insurance questions should be directed to the telephone number provided to you by your insurance company. Please Initial: ___________

How do you plan to pay for today's services? ☐ Cash ☐ Check ☐ Debit/Credit ☐ CareCredit Payment Plan

Please Initial: ____________

The point of service collections terms require a secure valid card be on hold for all patients. This card will only be charged in accordance with the terms listed below. Please Initial: ___________

1) We request the right to charge a missed appointment fee of 1/3 of your larger treatment appointment total or $50 per hour for hygiene appointments.
2) Your insurance company requires benefits be paid to the member opposed to the provider. Once services are preformed payment from patient is required in full, unless other payment arrangements have been made prior.

We Accept

Card Holder's Name: ____

Credit Card Number: ____

Expiration Date: ________________CV2 Code: __________________

Billing Zip Code: ________________ License State: ___________ Expiration Date: ____________

Appointment Scheduling Policy

A scheduled appointment is a commitment of time between the Doctor and the patient. We have reserved that time JUST FOR YOU. When appointments are missed or cancelled, the time is lost.

We ask that when you schedule your treatment, you make every effort to keep that commitment. We understand that personal emergencies do arise, and we always take that into consideration.

If you cannot keep your scheduled appointment, a 48-hour working day notice will allow us to schedule another patient in need of treatment.

I understand that a missed appointment fee of $50 per hour will be charged if a 48-hour working day notice is not given ___________ initial. We are not here currently on Wednesday's or weekends.

Dental Insurance

Out of courtesy and convenience for our patients we offer to file your insurance on your behalf. If you have dental insurance, it is the patient's responsibility to update their status information with our office. It is the patient's responsibility to stay abreast and informed of all insurance changes their policy invokes.

Financial Policies Continued

Third-Party Financing

Your Home Family Dentistry accepts payment from non-affiliated, third-party finance companies. Credit decisions are the responsibility of these third-party finance companies and of the patient.

I, undersigned, accept full financial responsibility for the treatment performed by this office, insurance forms will be completed as a convenience to the patients. Should the services of an attorney be required for collection of this account, I agree to pay reasonable attorney's fees, court costs, and other costs of collection.

Printed Full Name of Responsible Party: ____

Signature of Responsible Party: ____

Date: ________________________

Patient Signatures

Payment, Insurance, HIPAA, and Financial Arrangement Policies (signed by ALL patients)

By signing below, I (patient/guardian name) _____________________________________ acknowledge that I received the Payment, Insurance, and Financial Policies forms and agree to abide by such policies. I acknowledge that I have read the Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Release of Information to Insurers and Assignment of Benefits (must be signed by all patients with insurance and those who expect to obtain insurance). To the extent permitted by law, I consent to my practice (or their designees) use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claims. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize my direct payments of benefit to be authorized and payable to this dental office.

Printed Full Name of Patient: ____

Patient Date of Birth: __________________

Signature of Patient: ____

-OR-

Printed Full Name of Responsible Party: ____

Responsible Party Date of Birth: __________________

Signature of Responsible Party: ____

Date: ________________________

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section)

Your Home Family Dentistry
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Thank You!