

Patient Information Form

Today's Date _____

Patient Name: First _____ MI _____ Last _____ Nickname _____

Address: Street _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Mobile _____

E-mail address _____

By Providing your e-mail address you agree to receive (check one or both) Appointment Reminders Practice Newsletter

What is your preferred method of contact? Home Phone Work Phone Mobile Phone E-Mail

Social Security Number _____ Date of Birth _____

Drivers License # _____ State _____

Patient Employed By _____ Occupation _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

Sex Male Female Marital Status Married Single Divorced Separated Widowed

In case of emergency, who should be notified? _____

Relationship to Patient _____ Home Phone _____ Mobile Phone _____

Is the patient a Minor? Yes No Full-time Student Yes No Name of School _____

Name of Responsible Party: First _____ Last _____

Date of Birth _____ Relationship to Patient Self Spouse Parent Other _____

If patient is a Minor, primary residency Both Parents Mom Dad Step Parent Shared Custody Guardian

Address: (if different from patient) Street _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Mobile _____

Employer (if different from above) _____ Occupation _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

Dental Benefit Plan Information

Primary Dental Plan Name _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

Name of Insured _____ Date of Birth _____ ID Number _____

Policy Number _____ Patient Relationship to Insured _____

Secondary Dental Plan Name _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

Name of Insured _____ Date of Birth _____ ID Number _____

Policy Number _____ Patient Relationship to Insured _____

Medical Plan Information

Plan Name _____ Phone _____
Address: Street _____ City _____ State _____ Zip _____
Name of Insured _____ Date of Birth _____ ID Number _____
Policy Number _____ Patient Relationship to Insured _____ Deductible Amount _____

Whom may we thank for referring you?

- One of our valued patients (name of patient) _____
- Advertisement _____ Local Dental Society _____
- Our Web site Other _____

Please list other members of your immediate family who are patients in our practice

Patient Responsibilities: We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment _____

* Please note: If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.

Our practice IS / IS NOT (circle one) a contracted provider with your dental benefit plan.

If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

If we are not a contracted provider with your dental benefit plan, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

Scheduling of Appointments: We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on-time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of \$ 25 or deposit to reserve the appointment time again, may be required. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee of \$ 25 or deposit to reserve the appointment time again, may be required.

Authorizations: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. _____ (initial)

I have read the above and agree to the financial and scheduling terms. _____ (initial)

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. YES / NO (Circle One) _____ (initial)

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. _____ (initial)

I hereby acknowledge that a copy of this practice's Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. _____ (initial)

Signature _____ Date _____

Confidential Health History Form

Today's Date _____

Patient Name: First _____ MI _____ Last _____ Date of Birth _____

I. Circle appropriate answer (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
If NO, explain _____
2. Yes / No Has there been a change in your health within the last year?
If YES, explain _____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
If YES, explain _____
4. Yes / No Are you being treated by a physician now?
If YES, explain _____
Date of last medical exam? _____ Reason for exam _____
5. Yes / No Have you had problems with prior dental treatment?
If YES, explain _____
Date of last dental exam _____ Name of last treating dentist _____
6. Yes / No Are you in pain now?
If YES, explain _____

II. Have you experienced any of the following? (Please circle Yes or No for each)

- | | | |
|---|-----------------------------------|----------------------------------|
| Yes / No Chest pain (angina) | Yes / No Blood in stools | Yes / No Frequent vomiting |
| Yes / No Fainting spells | Yes / No Diarrhea or constipation | Yes / No Jaundice |
| Yes / No Recent significant weight loss | Yes / No Frequent urination | Yes / No Dry mouth |
| Yes / No Fever | Yes / No Difficulty urinating | Yes / No Excessive thirst |
| Yes / No Night sweats | Yes / No Ringing in ears | Yes / No Difficulty swallowing |
| Yes / No Persistent cough | Yes / No Headaches | Yes / No Swollen ankles |
| Yes / No Coughing up blood | Yes / No Dizziness | Yes / No Joint pain or stiffness |
| Yes / No Bleeding problems | Yes / No Blurred vision | Yes / No Shortness of breath |
| Yes / No Blood in urine | Yes / No Bruise easily | Yes / No Sinus problems |

III. Have you had or do you have any of the following? (Please circle Yes or No for each)

- | | | |
|--|--|-------------------------------------|
| Yes / No Heart disease | Yes / No Cosmetic surgery | Yes / No Eating disorders |
| Yes / No Family history of heart disease | Yes / No Surgeries | Yes / No Osteoporosis |
| Yes / No Heart attack | Yes / No Hospitalization | Yes / No Thyroid disease |
| Yes / No Artificial joint | Yes / No Diabetes | Yes / No Asthma |
| Yes / No Stomach problems or ulcers | Yes / No Family history of diabetes | Yes / No Hepatitis |
| Yes / No Heart defects | Yes / No Tumors or cancer | Yes / No Sexual transmitted disease |
| Yes / No Heart murmurs | Yes / No Chemotherapy | Yes / No Herpes |
| Yes / No Rheumatic fever | Yes / No Radiation | Yes / No Canker or cold sores |
| Yes / No Skin disease | Yes / No Arthritis, rheumatism | Yes / No Anemia |
| Yes / No Hardening of arteries | Yes / No Emphysema or other lung disease | Yes / No Liver disease |
| Yes / No High blood pressure | Yes / No Kidney or bladder disease | Yes / No Eye disease |
| Yes / No Seizures | Yes / No Stroke | Yes / No Transplants |
| | | Yes / No Tuberculosis |

This information will not be released unless specifically authorized by patient.

Yes / No AIDS/HIV Yes / No Anxiety Yes / No Depression Yes / No Treatment for emotional condition

IV. Are you allergic to or have you had a reaction to any of the following? (Please circle Yes or No for each)

- | | | |
|--|-----------------------|------------------------|
| Yes / No Aspirin | Yes / No Valium | Yes / No Tetracycline |
| Yes / No Darvon | Yes / No Demerol | Yes / No Vicodin |
| Yes / No Codeine | Yes / No Penicillin | Yes / No Percodan |
| Yes / No Latex | Yes / No Food | Yes / No Nitrous oxide |
| Yes / No Local anesthetic
(Novocain or Xylocaine) | Yes / No Erythromycin | Yes / No Metal |

Others _____

James L. Currier, D.D.S. Inc.

Financial Agreement and Insurance Acknowledgement

We are committed to providing you with the best possible 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. **PAYMENTS FOR SERVICES ARE DUE AT THE TIME SERVICES ARE RENDERED.** INIT _____

We accept cash, Visa, MasterCard, Discover, American Express, or financing available with the Dental fee plan. **SORRY, NO CHECKS.** BALANCES OLDER THAN 30 DAYS MAY BE SUBJECT TO ADDITIONAL COLLECTION FEES. Charges may also be made for broken appointments and appointments cancelled without 24 hour notice. We will gladly discuss your proposed treatment and answer any questions related to your insurance. INIT _____

We will be happy to process your insurance claim form. If your insurance company permits we will accept assignment of insurance benefits. Assignment of benefits is a "payment made directly to the Doctor by the insurance company for their portion of the service rendered." INIT _____

YOU MUST REALIZE THAT: Your insurance is a CONTRACT between YOU, your employer, and your insurance company. WE ARE NOT A PARTY TO THAT CONTRACT. INIT _____

Our fees are generally considered to fall within the acceptable range by most insurance companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of USUAL CUSTOMARY AND REASONABLE (UCR) fee for this region. Our fees are considered USUAL CUSTOMARY AND REASONABLE by most insurance companies. THIS STATEMENT DOES NOT APPLY TO COMPANIES WHO REIMBURSE BASED ON ANY ARBITRARY "SCHEDULE" FEES, WHICH BEAR NO RELATIONSHIP TO THE CURRENT STANDARD AND COST OF CARE IN THIS AREA. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services not cover. INIT _____

WE MUST EMPHASIZE THAT AS DENTAL CARE PROVIDERS, OUR RELATIONSHIP IS WITH YOU NOT YOUR INSURANCE COMPANY. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are ultimately your responsibility from the date services are rendered. WE WILL DO EVERYTHING POSSIBLE TO ASSIST YOU IN COLLECTING FROM THE INSURANCE COMPANY: HOWEVER, IF PAYMENT HAS NOT BEEN RECEIVED FROM THEM IN 45 DAYS OR WITH DUAL INSURANCE 60 DAYS WE EXPECT PAYMENT IN FULL FROM YOU AND HAVE THE INSURANCE COMPANY REIMBURSE YOU FOR THE SERVICE. INIT _____

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you. I, THE UNDERSIGNED, UNDERSTAND AND ACCEPT THE ABOVE STATED FINANCIAL ARRANGEMENT.

Signature _____ Date _____

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 have received, read and understand your *Notice of Privacy Practices* containing a more complete 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 Private 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:
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