Welcome to Our Office

We realize you have many choices for your dental care and do appreciate you choosing us for your dental needs. We are committed to providing you with the highest quality, state of the art dentistry, in a comprehensive, compassionate and cost effective manner.

GENERAL INFORMATION

- Insurance is a benefit to help defray the cost of your treatment and is a contract between you, your employer and the insurance company. As a courtesy, we will bill your insurance for all services rendered if you provide us with the necessary information.
- Although our staff will assist you whenever possible, you are expected to know and understand the exclusions, limitations, maximums and specifics of your insurance plan.
- The treatment we recommend will always be based on your individual needs rather than your insurance coverage. We will discuss the diagnosis, total cost of treatment and any assistance you may expect from your insurance. Please understand that not all necessary services are covered by your insurance company.
- Patients only are allowed in the treatment rooms. Parents will be called back only if necessary and then to discuss treatment.
- Our staff makes every effort to confirm appointments two days prior to the scheduled appointment; however, it is the patient's responsibility to keep track of his/her appointment dates and times.

INITIAL VISIT/RECALL VISITS/X-RAYS

- The initial visit will consist of a comprehensive oral evaluation and full mouth series of x-rays.
- Recall visits (every six months) will consist of a periodic exam, four bitewing x-rays and two periapical x-rays.
- Most insurance plans have frequency limitations and restrictions with respect to x-rays. If your insurance denies any or all of the x-rays at any visit you are responsible for any unpaid balance.
- X-rays are necessary in the diagnosis and treatment of patients. Refusal to allow all necessary x-rays to be taken may result in the doctor refusing to diagnose or perform treatment until the needed x-rays are obtained.
- I have read and understand the above x-ray policy. (initial: ___________)

PPO & PRIVATE INSURANCE

- We are contracted with most PPO insurance plans. If you are unsure if we are contracted with your plan please ask one of our front office staff.
- All co-pays quoted are estimates based on the information given to us by your insurance company. All co-pays/deductibles are due at the time services are rendered.
- If we are unable to verify your benefits or eligibility prior to your appointment, payment is due in full at the time the services are rendered.
- Most insurance companies will tell their members what percentages they will pay for certain procedures (i.e., 80 or 100%) but fail to explain that those percentages can be based on a fee schedule or usual and customary fees and may be subject to certain limitations and/or annual maximums. We will attempt to estimate your portion as close to the actual amounts as possible, however, if we do not have a copy of your insurance plan's fee schedule our calculation can only be an estimate. Any difference in our fees and those of you insurance are your responsibility.
- By signing this form I authorize Affordable Dental to affix my name to any and all claims or documents related to any and all health benefits due to me and/or my dependents. Additionally, I authorize payments of dental benefits otherwise payable to me to be paid directly to Affordable Dental. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan unless Affordable Dental has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable laws, I authorize the release of any information relating to any claim(s) submitted on my behalf.

NO INSURANCE

- Uninsured patients are required to pay for services in full at the time the service is rendered.
- In consideration to our patients with no insurance a courtesy savings is available. Please ask one of our front office staff for additional information.
- Outside financing is available with no money down, low monthly payments and interest free options. Please ask one of our front office staff for additional information.

MISSED APPOINTMENTS

Because we reserve your scheduled appointment time just for you, when you need to reschedule or cancel an appointment we do require at least a 24-hour notice. We reserve the right the charge $25.00 for any failed/rescheduled appointments without a 24-hour notice.

FINANCIAL POLICY/INFORMATION

- We accept local checks with a picture ID, Visa, MasterCard, Discover, American Express and cash. There is a $25.00 charge on all returned checks.
- Regardless of insurance coverage the patient/responsible party is ultimately responsible for all services rendered. If the insurance payment has not been received within 60 days of the date of service, any balance remaining is due and payable in full and may be increased by a 1.5% monthly finance charge.
- The patient/responsible party agrees to pay any attorney's fees, collection fees and/or court costs that may be incurred to satisfy their obligation.

PATIENT PRIVACY CONSENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1998 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information and to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (i.e., my insurance company);
- The day-to-day healthcare operations of the practice.

I have also been informed of, and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosure of my protected health information, and my right under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with the restriction(s).

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I have read and agree to the above.

____

Patient/responsible party signature Date

Patient Information

Today's Date: ___________________

Patient Name: _____________________________________ **Preferred Name:** ____________________

Patient Address: _____________________________________ Male Female

City: ____________ State: _______ Zip Code: ___________ Married Single Child Other

Patient Date of Birth: _____/_____/_____ **Patient Social Security #:** ________/________/________

Home #: (_____) ________________ **Work #:** (_____) ________________ **Pager/Cell:** (_____) _____________

Email address: ____

Patient Employer: __________________________________ **Occupation:** ___________________________

Whom may we thank for referring you to our practice? ____

In case of an emergency, whom shall we call?

Name: ________________________________ **Relationship:** ____________________ **Phone #:** __________________

Do you have or have you ever had any of the following? Please check ALL that apply:

NONE	Epilepsy	Jaundice	Stomach Problems
AIDS/HIV	Excessive Bleeding	Kidney Disease	Stroke
Anemia	Fainting	Liver Disease	Tuberculosis
Arthritis	Glaucoma	Mental Disorders	Tumors
Artificial Joints	Growths	Mitral Valve Prolapse	Ulcers
Asthma	Hay Fever	Nervous Disorders	Other:
Blood Disease	Head Injury	Pacemaker	______________
Breast Implants	Heart Disease	Radiation Treatment	
Cancer	Heart Murmur	Respiratory Problems	
Diabetes	Hepatitis _________	Rheumatic Fever	
Dizziness	High Blood Pressure	Sinus Problems	

Are you allergic to any of the following?

NONE	Codeine	Latex	Anesthetic
Sulfa	Penicillin	Erythromycin	Other ____________

Date of Last Dental Visit: ____________________ **Reason for today's visit:** ____________________________

Are you happy with your smile? YES NO

If no, what would you like to achieve? ____

How often do you brush? ______________________ **How often do you floss?** _________________________

Are you interested in straighter teeth? YES NO

Are you interested in cosmetic dentistry? YES NO

Are you interested in teeth whitening? YES NO

Are you concerned about bad breath? YES NO

Are you interested in learning more about dental implants? YES NO

Do you smoke or use chewing tobacco? YES NO

Do you drink a lot of coffee/tea/soda? YES NO

Do your gums bleed while brushing or flossing? YES NO

Do your gums feel tender or swollen? YES NO

Do you clench or grind your teeth during the day or while sleeping? YES NO

Are you interested in replacing your old amalgam fillings with tooth-colored, non-metal fillings?

YES NO

Have you ever had any complications following dental treatment? YES NO
If yes, please explain: ____

Have you ever taken Fen-Phen or Redux? YES NO

Have you been admitted to a hospital or needed emergency care during the past two years? YES NO
If yes, please explain: ____

Are you now under the care of a physician? YES NO
If yes, please explain: ____

Name of Physician: ______________________ **Phone #:** (_____) __________________

Do you have any health problems that need further clarification? YES NO
If yes, please explain: ____

What, if any medications are you taking at this time?

____

____

WOMEN: A**re you pregnant?** YES NO **If yes, expected due date:** ____/____/____

Insurance Information

Primary:

Insurance Plan Name: ______________________________

Group # ______________________

Phone #: (_____) ______________

Name of Insured: ______________________________ (If different from patient)

Insured Date of Birth: _____/_____/_____

Insured Social Security #: __________/________/__________

Secondary:

Insurance Plan Name: ______________________________

Group # ______________________

Phone #: (_____) ______________

Name of Insured: ______________________________ (If different from patient)

Insured Date of Birth: _____/_____/_____

Insured Social Security #: __________/________/__________

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 doctor at the next appointment without fail.

______________________________________ ______________________________________
Signature of patient, parent or guardian Date Doctor Signature Date