

Dickinson Dental Policy and Patient Authorization Form

Broken Appointment Policy: We at Dickinson Dental respect and value our patients. Out of respect to our patients we strive to stay on schedule. It is important for our patients to understand that an appointment is a time set aside for you. Due to this, it is imperative that you give our office ample time if you need to reschedule your appointment. Our policy is 48 hours notice for rescheduled appointments. If 48 hours notice is not given, it will be deemed a broken appointment. The broken appointment charge is \$35. Please initial Financial Policy: Payment is due when services are rendered. We at Dickinson Dental realize that dental insurance is a confusing and sometimes overwhelming experience for our patients. As a result, we will agree to file your insurance as a courtesy to you. After 60 days, you (the patient) are responsible for any balance on your account not paid by the insurance company for any reason. Insurance does not guarantee payment for any service until the insurance claim is received. Therefore, we cannot guarantee your insurance will pay. Treatment plans given are estimates of insurance benefits and are not a guarantee of payment. Dickinson Dental is a provider for many insurance companies. As a result, we accept the insurance portion as payment and require the patient portion at the time of service. For these insurances that we are not "providers" for, we ask those patients to pay up front for all services and the insurance company will reimburse you, the patient, directly. Please initial Patient Authorization Signature: The undersigned hereby authorizes the release of any information relating to all claims for the benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for the benefits for services rendered or for services to be rendered without obtaining my signature on each and every claim. I will be bound by this signature as though the undersigned had personally signed the particular claim. Please initial I hereby do accept and agree to the terms as listed above.

Authorized Signature of Patient or Patient Guardian

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 form third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the use and disclosure of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization at any time at the address below to obtain a current copy of the Notice of Privacy 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.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

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Signature:	Initial seasible
Relationship to Patient:	to at Ambortzation Signatures. The underespool barely suf- cent ation relating to all citatus for the perefits colmitted on but
I authorize	to have access to my records.
Date:	the undersigned had personally signed the pr

PATIENT'S DENTAL HISTORY

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PATIENT'S MEDICAL HISTORY PATIENT'S NAME DATE OF BIRTH ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS. YES NO YES NO 1. ARE YOU IN GOOD HEALTH..... 12. HAVE YOU EVER TAKEN FEN-PHEN/REDUX 2. HAVE THERE BEEN ANY CHANGES IN YOUR 13. HAVE YOU EVER TAKEN FOSAMAX, BONIVA. GENERAL HEALTH WITHIN THE PAST YEAR ACTONEL OR ANY CANCER MEDICATIONS DATE OF YOUR LAST PHYSICAL EXAM: CONTAINING BISPHOSPHONATES? 4. PHYSICIAN'S NAME 14. HAVE YOU TAKEN VIAGRA, REVATIO, CIALIS OR ADDRESS LAVITRA IN THE LAST 24 HOURS?..... PHONE NO. 15. DO YOU USE TOBACCO ARE YOU NOW UNDER THE CARE OF A 16. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES 6. HAVE YOU EVER BEEN HOSPITALIZED FOR 17. ARE YOU WEARING CONTACT LENSES ANY SURGICAL OPERATION OR SERIOUS ILLNESS 18. DO YOU HAVE A PERSISTENT COUGH OR THROAT PLEASE EXPLAIN. __ CLEARING NOT ASSOCIATED WITH A KNOWN 7. ARE YOU TAKING ANY MEDICINE(S) ILLNESS (LASTING MORE THAN 3 WEEKS) INCLUDING NON-PRESCRIPTION MEDICINE . . . 19. DO YOU HAVE ANY DISEASE, CONDITION OR IF YES, WHAT MEDICINE(S) ARE YOU TAKING PROBLEM NOT LISTED ABOVE THAT YOU THINK 8. HAVE YOU HAD ANY ABNORMAL BLEEDING. . . . WOMEN ONLY: 9. DO YOU BRUISE EASILY..... ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT . . . 10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION ARE YOU NURSING..... 11. HAVE YOU HAD A RECENT WEIGHT LOSS..... ARE YOU TAKING BIRTH CONTROL PILLS YES NO ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO: LOCAL ANESTHETICS LIKE NOVOCAINE..... SULFA DRUGS...... BARBITURATES, SEDATIVES OR SLEEPING PILLS . . IODINE..... JOINT REPLACEMENT OR IMPLANT ANY METALS (E.G., NICKEL, MERCURY, ETC.). . . . OTHER (PLEASE LIST) DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING: RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER CHEMOTHERAPY (CANCER, LEUKEMIA)..... SCARLET FEVER.... HEART TROUBLE, HEART ATTACK, OR ANGINA . . . GLAUCOMA SHORTNESS OF BREATH..... HIGH/LOW BLOOD PRESSURE

TEM 27011

CONGENITAL HEART PROBLEM.....

SWELLING OF FEET, ANKLES, HANDS.

HEPATITIS, JAUNDICE OR LIVER DISEASE

STROKE

SINUS TROUBLE

MENTAL HEALTH CARE.....

BACK PROBLEMS

CHEMICAL DEPENDENCY.....

CORTISONE TREATMENT.....

EATING DISORDERS....

NAME	MI			DATE	
ADDRESS	MI	LAST		STATE/	ZIP/
ADDRESS	0511 0110115	CITY		PROV	P.C
E-MAIL			HOME	PHONE	
SS#/SIN	BIRTHDATE		_		
CHECK APPROPRIATE BOX:	☐ MINOR ☐ SINGLE	MARRIED	DIVORCE	D WIDO	WED SEPARAT
F COLLEGE STUDENT, F.T. /	P.T., NAME OF SCHOOL			CITY	PROV
PATIENT'S OR PARENT'S/GU/ BUSINESS ADDRESS	ARDIAN'S EMPLOYER			WORK PHO	NE
BUSINESS ADDRESS		CITY		PROV.	f.'.c'
SPOUSE OR PARENT'S/GUAR	DIAN'S NAME	EMPLOYER		_ WORK PHO	NE
WHOM MAY WE THANK FOR	REFERRING YOU?				
PERSON TO CONTACT IN CA	SE OF AN EMERGENCY			_ PHONE	
RESPONSIBLE PARTY	(
				RELATIONSH	IP
NAME OF PERSON RESPONS	IBLE FOR THIS ACCOUNT			TO PATIENT	
ADDRESS			_ HOME	PHONE	-
DRIVER'S LICENSE #	BIRTHDA	TE	SS#/SIN		
MPLOYER			WORK F	PHONE	
S THIS PERSON CURRENTLY	A PATIENT IN OUR OFFIC	E? YES	□ NO		
INSURANCE INFORM	IATION	E? YES	□ NO	RELATIONSHI	P
NSURANCE INFORM	IATION			RELATIONSHI TO PATIENT_	
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X SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

PATIENT NUMBER