

Dana E. Wright

DENTAL STUDIO

FAMILY | COSMETIC

WELCOME

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

Date _____

PATIENT INFORMATION

Name of Minor/Child _____
Last Name First Name Initial

Sex M F Age _____ Birthdate _____ Nickname _____

Home Address _____
City State Zip

Person financially responsible _____ Home Phone _____ Work Phone _____

Whom may we thank for referring you? _____

INSURANCE

Father's /Guardian's Name _____ Address (if different from patient's) _____ Home Phone _____ Work Phone _____ <small style="margin-left: 50px;">(if different from above)</small> <small style="margin-left: 100px;">(if different from above)</small> Employer _____ Soc. Sec. # _____ Birthdate _____ Do you have dental insurance coverage for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No Plan Name _____ Phone No. _____ Address _____ Group # _____ Policy # _____	Mother's /Guardian's Name _____ Address (if different from patient's) _____ Home Phone _____ Work Phone _____ <small style="margin-left: 50px;">(if different from above)</small> <small style="margin-left: 100px;">(if different from above)</small> Employer _____ Soc. Sec. # _____ Birthdate _____ Do you have dental insurance coverage for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No Plan Name _____ Phone No. _____ Address _____ Group # _____ Policy # _____
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Is your child eligible for treatment under Medical Assistance? Yes No Child's Medical Assistance I.D. # _____

DENTAL HISTORY

Date of last visit to a dentist _____ For what service? _____

Has child complained about dental problems? <input type="checkbox"/> YES <input type="checkbox"/> NO Does child brush teeth daily? <input type="checkbox"/> YES <input type="checkbox"/> NO Does child use floss every day? <input type="checkbox"/> YES <input type="checkbox"/> NO Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is fluoride taken in any form? <input type="checkbox"/> YES <input type="checkbox"/> NO Any injuries to mouth, teeth, head? <input type="checkbox"/> YES <input type="checkbox"/> NO Any unhappy dental experiences? <input type="checkbox"/> YES <input type="checkbox"/> NO
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Please Complete Both Sides

MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone _____

Date of last physical examination _____ Results _____

	YES	NO	
Is Minor/Child under care of physician now?	<input type="checkbox"/>	<input type="checkbox"/>	Medications _____
Receiving any medication or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Allergies _____
Is there excessive bleeding when cut?	<input type="checkbox"/>	<input type="checkbox"/>	_____

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CHECK (✓)

- | | | | | |
|-------------------------------------------|---------------------------------------------|-------------------------------------------|-----------------------------------------|------------------------------------------|
| <input type="checkbox"/> A.I.D.S./H.I.V. | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other |

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

AUTHORIZATION

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child.

Signature of Parent/Guardian _____

Date _____

I certify that my minor/child is covered by insurance with:

_____ Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent/Guardian _____

Date _____



UPDATE

TO BE COMPLETED AT LATER VISIT

Has there been any change in patient's health since last dental appointment? Yes No

If yes, please describe _____

Is patient taking any new medications? Yes No If yes, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND
CONSENT / LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ E-mail: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

Please **print** name of Patient

Please **sign** for Patient/Guardian of Patient

Legal Representative/Guardian

Relationship of Legal Representative Guardian

Your comments regarding Acknowledgements: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

First Name Only Proper Sir Name Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENTS, & BILLING INFORMATION** VIA:

- | | |
|--------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> Any of the Above |

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- | | |
|--------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> Any of the Above |

In signing this HIPAA Omnibus Patient Acknowledgement Form, you authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's signature on this Acknowledgement but did not because:

- | | |
|------------------------------------------|--------------------------|
| It was emergency treatment | <input type="checkbox"/> |
| I could not communicate with the patient | <input type="checkbox"/> |
| The patient refused to sign | <input type="checkbox"/> |
| The patient was unable to sign because: | _____ |

Signature of Privacy Officer

Financial Policy of Dana E. Wright, D.D.S.

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health. Please understand that payment is considered part of your treatment. The following statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover and Care Credit.

Please note: Returned checks will be subject to additional fees.

If you have insurance:

- As a courtesy to you, we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, MasterCard, Visa or Care Credit at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 30 days, we will ask that you contact your insurance company to make sure payment is expected soon. If payment by your insurance company is not received within 60 days, or your claim is denied, you will be responsible for paying the full amount at that time.

We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Minors with Separated or Divorced Parents:

When two parents are each responsible for one half of the cost of a child's dental care, the Parent or Guardian who brings the child is responsible for the co-insurance or the full fee. They will also be responsible for collecting payment from the other parent.

For your convenience, we also offer automatic payments to your credit card as a form of payment. Please let us know if you would like to use this method of payment, as there is an additional authorization form to sign.

Thank you for the opportunity to serve your dental health care needs.

In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred, along with any charges associated with those agencies, and/or finance charges. I/we agree that in the event of default in payment, reasonable collection agency fees equal to fifty (50%) percent of the delinquent balance and reasonable attorney fees, shall be added to the amount due on the account, plus any applicable court costs.

Initials

Date

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

Patient Name

Signature of Guarantor, if Minor

Date