Mill Dam Dental Care

Dr. Jeffrey R. Leidy
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PERSONAL HISTORY

Patient Name _____ Birth Date_____ SS#_____

Address _____

City _____ State _____ Zip _____

Employer _____ Occupation _____

Home Phone # _____ Work Phone # _____ Cell Phone# _____

Preferred Name_____E-mail address_____

Marital Status: ___ Single __ Married __ Separated __ Divorced __ Child __ Other

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IF PATIENT IS UNDER 18 YEARS OF AGE

Person responsible for account of minor child_____Relationship to patient _____

Address [if different from above] _____

Home phone # _____ Work phone # _____ Cell Phone # _____

Place of Employment _____ Birth Date _____ SS#_____

Do you have **dental** insurance? _____ Yes _____ No

Dental Insurance company name _____

Subscriber name _____ Birth date _____ ID#_____

Group name _____ Group # _____ Phone # _____

Do you have **secondary dental** insurance? _____Yes _____No

Dental Insurance company name _____

Subscriber name _____ Birth date _____ID#_____

Group name _____Group # _____Phone #_____

What is the reason for your visit? _____
_____
Are you in pain now? _____ Date of last dental visit _____
Is there anything about your smile that you would like to change? _____
_____

What do you want your teeth to look like in 20 years? _____
_____

Does dental treatment make you nervous? _____

_____ Health History_____

Do you now have, or have you had, any of the following conditions or diseases? Check all that apply.

__Congenital Heart Disease	__Heart Murmur	__Cancer	__Rheumatic Fever
__High Blood Pressure	__Heart Attack	__Pacemaker	__Hemophilia
__Artificial Heart Valve	__Hepatitis	__Venereal Disease	__AIDS/HIV
__Sensitivity to Metals	__Oral Cancer	__Diabetes (Type:____)	__Birth Defects
__Fainting/Dizziness	__Eating Disorder	__Latex Sensitivity	__Epilepsy
__Drug/Substance Abuse	__Asthma	__Allergy to Anesthetics	__Used Fen-Phen
__Taking Birth Control	__Seasonal Allergies	__ADD/ADHD	__Stroke
__Psychiatric Care	__Nervous Disorders	__Jaw Pain	__Smoke
__Biphosphate Compounds (Actonel, Fosamax, etc.)	__ Artificial Joints (Joint Type: _____)	__Smokeless Tobacco Use __Radiation/Chemotherapy	__Organ Transplant (OrganType:_____)

Check and describe any of the following conditions that apply.

___ Respiratory Problems _____ ___ Heart Surgery _____
___ Stomach Problems _____ ___ Retinal Surgery _____
___ Sinus Problems _____ ___ Kidney Problems _____
___ Pregnant now (*if yes, due date*: _____) ___ Breastfeeding now
___ Retinal Surgery (*if yes, please indicate date and type of procedure*) _____
___ Previous Surgeries (*type & date*)_____
___ Received Antibiotics Prior to Dental Treatment in the Past (if yes, why? _____)
Other (please specify)_____

Are you allergic to any medications? *Circle One:* No Yes (*if yes, please list*)_____

_____

_____

Please list ANY and ALL medications you are now taking and why you are taking them.

_____

_____

Please list ANY and All Herbal Supplements _____
Please give your height and weight _____
Do you have a family history of Diabetes?_____
Do you fatigue easily?_____
Do you heal slowly? _____
Do you have frequent infections? _____

PCP Name (Medical Doctor) _____ PCP Phone # _____

Emergency contact _____ Phone # _____ Relationship to patient_____

To the best of my knowledge, all preceding answers are true and correct. I also agree to notify the office immediately of any changes in the above information.

I hereby apply for treatment by the above dentists, their associates, and / or assistants. Treatment may include X-rays, injections, and / or such office procedures deemed necessary, and, I accept the risks and complications associated with such procedures.

I authorize the release and use of dental records gathered by his office as they deem necessary, including study models, photographs, and radiographs. I also authorize the release of information necessary for filing any dental insurance; and direct payments to the office for any amounts due on my claim under the stated policies or any other policy I may be asked to be filed. I have been given a notice of privacy practices for this office and agree to all information contained within.

I understand that a parent or adult guardian must accompany my minor child and stay in the office until their dental treatment is completed.

Signature _____ Date _____

_____ Mill Dam Dental Care _____

As a courtesy to our patients, we will file dental insurance claims to the companies with whom we participate with on your behalf. However, we need to inform you of our financial policy that states if the reimbursement is not received within forty-five (45) calendar days, from the date of treatment, the entire cost of the treatment becomes the responsibility of the patient or the person designated as the guarantor.

If you are a patient who has dental insurance with a company with whom we do not participate, we will give you an estimate of the cost for your dental treatment, but you are also responsible for anything not covered by your insurance. **It is important that you understand that any insurance policy you have is an agreement between you and the company and we cannot get involved in any dispute, conflict, interpretation, or any other insurance related problem.**

I understand that this office is NOT a Medicare provider and will not file claims with Medicare on my behalf. I also understand that I do not have authorization to file claims with Medicare for services rendered in this office.

All patients who subscribe to a DMO insurance plan will be required to pay any and all co-payments in full at the time of service.

If you are a patient who will be undergoing sedation dentistry, please be advised that sleep dentistry is a very new procedure that is not yet recognized for reimbursement by insurance companies. Therefore, payment for sedation is the responsibility of the patient or guarantor and must be paid in full prior to treatment being rendered. Although the sedation will not be covered, your insurance company will reimburse you for any benefits that they do allow under your individual plan.

I agree to be financially responsible for the cost of all services rendered to the patient by this office, and, I understand that if payment is not made when due, I agree to pay interest on the balance at 1.5 % monthly (18 % annually). In the event legal action results in this going to court, I agree to pay attorney fees equal to 40 % of the total amount due, plus all allowable court costs. I agree to pay $ 50.00 for any returned checks, in addition to the other terms set forth in the above paragraphs.

I am aware that I am responsible for payment for all services rendered if there is an insurance dispute, refusal to pay, or, if payment is not received from my insurance company within 45 days of the treatment. For value received, I guarantee the payment terms as set forth above.

SEDATION APPOINTMENTS

The amount of time scheduled for sedation appointments is an estimate. If the sedation appointment time runs over the amount estimated you will not be charged for the additional time; likewise, if the sedation appointment time runs less than we estimated, a refund will not be issued. When scheduling sedation appointments, 25% of the total amount of treatment is required at time of scheduling to reserve the appointment date and time. If you miss your appointment or cancel without giving two business days notice, your down payment will not be refunded.

APPOINTMENT POLICY

We respect the importance of your time and work very hard to schedule appointments that accommodate the busy needs of all our patients. In return, we ask that our patients make every effort not to change reserved dental appointments. Broken or missed appointments create scheduling problems for other patients and our dental practice as well. With this in mind, we reserve the right to charge for missed or broken appointments without two business days notice.

I understand and agree to the terms set forth above regarding insurance and appointment policies.

GUARANTOR SIGNATURE _____ DATE: _____

_____ Mill Dam Dental Care _____

Consent for Testing

In order to comply with the Occupational Safety & Health Administration Bloodbourne Pathogen Regulation (OSHA), we are requesting your consent to submit to testing of your blood for bloodbourne pathogens (hepatitis B, hepatitis C or HIV) **if an exposure occurs** (needlestick injury, blood spatter) to one of the staff. Testing will be done at no cost to you. All information regarding an exposure is confidential.

Date: _____ Signature: _____

Privacy Statement

In order to comply with the new privacy rules governing the sharing of medical information for billing purposes, we need your permission to do the following. Please sign this form to allow for the billing of insurance for your care. Please mark the appropriate blocks for additional permissions.

- ❑ **May leave messages on my voice mail/answering machine**
- ❑ May fax information to my fax number
- ❑ **May email information to my email address and/or text to my cell phone number**
- ❑ May share information with the following members of my family:
  ***LIST NAMES AND RELATIONSHIP BELOW:**

- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____

Date: _____ Signature: _____

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HIPAA PRIVACY OF PATIENT HEALTH CARE INFORMATION

Because there can be questions of privacy when health care information is transmitted electronically, the Congress has established an all-inclusive sweeping privacy law called the Health Insurance Portability and Accountability Act (HIPAA) to be administered by the Department of Health and Human Services. The Act established standards for health care providers in obtaining and disclosing your personal health information.

Although such information exchange has been routine in the past, and even though we have never had a problem, the law mandates that you must now give specific written consent to continue these traditional communications relating to your personal health information in order to plan and accomplish optimum treatment, to convey and receive pertinent health information, and to facilitate payment.

We fully respect the privacy of your medical records, and we will continue to do all we can to make them secure and to protect their confidentiality. In order to provide the best possible health care and/or to help third parties involved with payment of your account we routinely share and request pertinent health information only with your other medical or dental caregivers, with other concerned parties such as relatives, and with others involved in account payment such as insurers, etc. We may from time to time need to confirm or discuss appointments or to discuss care related concerns on your home answering machine or directly to those answering your home phone or to phone callers identifying themselves as a relative or concerned party

In the course of your treatment we sometimes have to disclose or receive your personal health information from other treatment related facilities (such as laboratories, sleep clinics, pathologists, and radiologists) that might not be required to obtain your consent to release to us products or reports relating to your personal health.

HIPAA allows you to consent or refuse to the use or disclosure of your personal health information as described above, but consent or refusal must be in writing. HIPAA does recognize the necessity of information exchange for optimum patient care, and it has provided for denial of treatment if you choose not to consent. If you choose to give consent by signing this document, you have the future right to revoke or restrict part or all of this Personal Health Care Information Agreement, but you may not revoke or restrict actions that have already been taken that relied on this or a previously signed consent. Of course you personally have the right at any time to access any information we have in your personal health records. Your signature below indicates your consent.

Please ask for our Privacy Coordinator if you have any questions concerning this form or if you desire to review a full copy of our Notice of Privacy Practices.

If you think that we may have violated your privacy rights, contact our Privacy Coordinator. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

_____ _____

Signature Date

_____

Print Name