New Patient Information Form

Personal Information

Last Name _____ First Name _____ MI _____

Street _____ City _____ State _____ Zip Code _____

Birth Date _____ Age _____ Gender _____ Marital Status _____

Driver's License # _____ S.S. # _____ Other I.D. # _____

Contact Information

Home Phone _____ Work Phone _____ Best time to call _____

Fax _____ Cell _____ Email _____

How did you hear about us? (Google, Facebook, referral, etc.) _____

Employer

Name _____ Address _____ Phone _____

_____

Responsible Party

Name _____ Address _____ Phone _____

_____

Primary Insurance Provider

Company Name _____ Address _____

Phone _____ Group Number _____

Family Members

Name	Birth Date	Age	Address

Medical History Form

PATIENT NAME: _____

Medical History

Yes	No		
☐	☐	1.	Are you currently under the care of a physician?
☐	☐	2.	Are you currently taking any medication?
☐	☐	3.	Are you allergic to any medication?
☐	☐	4.	Have you ever had a rheumatic fever, heart surgery, a heart murmur, or a joint replacement?
☐	☐	5.	Have you ever had cancer, radiation treatment, or chemotherapy?
☐	☐	6.	Have you ever had a reaction to local anesthetic (Novocain) or general anesthetic?
☐	☐	7.	Have you ever had any injury to your face or jaw?
☐	☐	8.	Do you have high or low blood pressure? ☐ High ☐ Low
☐	☐	9.	Have you had a heart attack, chest pains, or a pacemaker?
☐	☐	10.	Have you had shortness of breath, asthma, tuberculosis, or any other breathing problems?
☐	☐	11.	Do you have intestinal or stomach problems?
☐	☐	12.	Have you had kidney or bladder trouble?
☐	☐	13.	Have you had hepatitis, jaundice, or liver disease?
☐	☐	14.	Do you or anyone in your family have diabetes? Who? _____
☐	☐	15.	Have you had a stroke, seizure, or convulsive disorder?
☐	☐	16.	Do you have arthritis or rheumatism?
☐	☐	17.	Do you have a tendency to bleed longer than normal?
☐	☐	18.	Do you have a bleeding disorder such as anemia or leukemia?
☐	☐	19.	Have you been hospitalized in the last 5 years?
☐	☐	20.	Have you tested positive for HIV or Aids virus?
☐	☐	21.	Are you or have you been treated for chemical dependency?
☐	☐	22.	Do you use tobacco?
☐	☐	23.	Have you taken any of the following medications in the last 6 months?
☐	☐		☐ Cortisone or other steroids
☐	☐		☐ Anticoagulants or blood thinner
☐	☐		☐ Tranquilizers or antidepressants
☐	☐		☐ Aspirin in large doses or frequently
☐	☐	24.	Do you have any other health problems? If so, please list: _____
☐	☐	25.	Are you pregnant?
☐	☐	26.	Are you taking birth control pills?

Doctor's comments _____

Dental History Form

PATIENT NAME: _____

1. What is the reason for coming to our dental office today?

   _____

2. How long has it been since you have seen a dentist?

   _____

3. Have you ever had any complications during or following dental treatment? ☐ Yes ☐ No
   If yes, please explain. _____

4. Do you have pain, soreness, or clicking in your jaw joints jaw muscles? ☐ Yes ☐ No
   If yes, please explain. _____

5. Are there any other dental concerns or problems you have? ☐ Yes ☐ No
   If yes, please explain. _____

To the best of my knowledge, all of the preceding answers are true and correct. If I have any change in my health, or if my medications change, I will inform this office at the next appointment without fail.

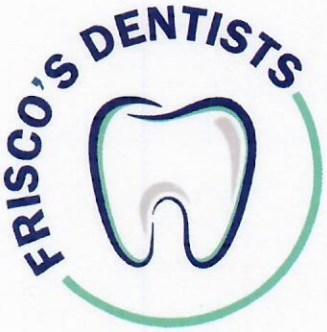
Payment Information

Payment is due on the day of treatment.

There are no payment plans for any services rendered under $100.00. For procedures that require more than one visit, half the fee is due the day the procedure is started, and the other half is due by the time the procedure is completed. If this presents a problem, you must speak with the receptionist at this time about any issues you have. Finance charges are 18% per year and accrue on all accounts over 30 days old. Accounts 90 days past due are turned over to a collection agency. We accept MasterCard, Visa, Discover, cash, and personal checks.

Patient (parent or guardian) signature _____ Date _____

Doctor's signature _____ Date _____



Office Financial Policies and Payment Options

We are pleased to welcome you to our office. New patients are always appreciated. Our practice has grown because of its excellent relationship with our referring doctors and patients. As our patients, feel free, at any time, to express concerns or to ask any questions that you may have for Dr. Neal or our staff. In order to assist you in making payment for your treatment, the following options are listed. Please read them carefully and feel free to discuss them with us.

Payments

You may make any payment using cash, check, MasterCard, Visa, or Discover.

Uninsured patients

If you do not have insurance, payment is due in full at the time treatment is provided.

Insured patients

If you have dental insurance, we will submit your dental claim to your insurance carrier for you. You will be asked to present a current insurance card.

You are responsible, at the appointment time, for any deductible and/or patient portion not covered by your dental insurance.

If the exact amount covered by insurance cannot be determined at the time of your appointment, we request that you pay your deductible and 20-50% of the remaining cost of your treatment. Once our office has received payment from your dental insurance, you will be billed for any amounts still owed or you may fill out a voucher and have the amounts applied to your credit card.

Important information for insured patients

The amount of coverage paid by your dental insurance company may be based on your dental insurance company's own reduced fee schedule for treatment and may be less than the actual charges resulting in lower coverage to you. WE have no control over this situation. Lower payment is a direct result of the plan selected by your employer. Please be advised that we cannot waive patient portion payment. We are required by law to collect your patient portion.

Dental insurance companies are required by law to reimburse this office within 30 days of being billed. Delayed payment may result in your being required to pay the covered portion. We urge you to insist that your dental insurance company make payment in a timely manner.

Special arrangements

Special arrangements may be made for large cases. Please see our Office Administrator.

Financial responsibility acknowledgment

I have read and understand these office policies.

Patient or Parent, if minor, Signature:_____ Today's Date: _____

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: _____

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 Patient

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

_____ _____

Legal Representative / Guardian

Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

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, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

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

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and 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 (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____

Signature of Privacy Officer

Authorization and Consent
To Send Unencrypted Patient Information by Email and Other Electronic Means

Until I tell you in writing to stop, I authorize Frisco Smile Solutions to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or Frisco Smile Solutions health care operations. The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment, and payment records.

I understand that:

- I do not have to sign this form.
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I don't sign this form, Frisco Smile Solutions may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be redisclosed and no longer protected by privacy law.
- Frisco Smile Solutions does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that Frisco Smile Solutions already sent before receiving my written instructions to stop.

Patient name (please print) _____

Signature: _____ Date: _____

Dental Team: Give a copy of this signed form to the patient. Save the original in the patient's file.