Advantage Dentists
Family Dentistry

Thank you in advance for taking the time to allow your new dental team the opportunity to get to know you better.

How did you first hear of Advantage Dentists?

☐ Billboard ☐ Google ☐ Mailer
☐ Drive by ☐ Insurance ☐ Website
☐ Referred by existing patient _____

Smile and Oral Health Evaluation

Patient Name _____ Preferred First Name _____

What did you like about your previous dental experiences?

_____

What did you not like about your previous dental experiences?

_____

Is there anything we can do to make your visit more comfortable? ☐ Yes ☐ No

_____

Rate how anxious you are about dental treatment.	Not anxious at all	1	2	3	4	5	6	7	8	9	10	Extremely anxious
Rate your overall oral health.	Poor	1	2	3	4	5	6	7	8	9	10	Excellent
Rate the appearance of your smile.	Poor	1	2	3	4	5	6	7	8	9	10	Excellent
Rate the color of your teeth?	Poor	1	2	3	4	5	6	7	8	9	10	Excellent
Rate your concern with mercury fillings.	Not concerned	1	2	3	4	5	6	7	8	9	10	Extremely concerned
Rate the straightness of your teeth.	Very crooked	1	2	3	4	5	6	7	8	9	10	Very straight
Are you concerned with losing or missing teeth?	Not concerned	1	2	3	4	5	6	7	8	9	10	Extremely concerned

Is there anything we can do to enhance your smile and optimize your oral health? ☐ Yes ☐ No

_____

Patient Information

Patient Name | Preferred First Name

Address | City | State | Zip Code

Cell Phone | Home Phone | Email

Marital Status ☐ Single ☐ Married ☐ n/a (patient is a child) | Gender | Age | Date of birth | Social Security Number

Employer | Occupation | Work Phone

Emergency Contact Name | Emergency Contact Phone

Parent or Guardian Information (if patient is under the age of 18)

Parent or Guardian Name | Relationship to Child

Address | City | State | Zip Code

Cell Phone | Home Phone | Email

Gender | Age | Date of birth | Social Security Number

Employer | Occupation | Work Phone

Employer Address | City | State | Zip Code

Insurance Information

Primary Insured (subscriber) | Relationship to Patient | Date of Birth

Subscriber Employer or Plan Sponsor | Insurance Company | Subscriber ID# | Group #

Additional Insurance

Primary Insured (subscriber) | Relationship to Patient | Date of Birth

Subscriber Employer or Plan Sponsor | Insurance Company | Subscriber ID# | Group #

Authorization and Release

I authorize my insurance company to pay Advantage Dentists all insurance benefits otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges not paid by insurance.** Advantage Dentists may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for the services and determining insurance benefits payable for related services, as pertaining to the HIPAA guidelines.

Patient or Parent Signature | Patient Name | Date

Dental History

Reason for today's visit: _____

How often do you brush? _____ How often do you floss? _____ Approximate date of your last dental visit _____

Please check all that apply.

- ☐ Toothache
- ☐ Loose, chipped, cracked or broken fillings
- ☐ Loose, chipped, cracked or broken teeth
- ☐ Food catches
- ☐ Flossing breaks or hurts
- ☐ Pain, clicking or popping of jaw
- ☐ Grinding of teeth
- ☐ Clenching of jaw
- ☐ Headaches
- ☐ Snoring or sleep apnea
- ☐ Sensitivity
  - ☐ Cold
  - ☐ Hot
  - ☐ Sweet
  - ☐ Chewing
  - ☐ Touch
- ☐ Sinus problem
- ☐ Gagging
- ☐ Dry mouth
- ☐ Dark or white spots on teeth
- ☐ Gums
  - ☐ Bleeding
  - ☐ Tender or sore
- ☐ Loose teeth
- ☐ Teeth have shifted
- ☐ Bad breath
- ☐ Bad taste in mouth
- ☐ Sores or growths in mouth
- ☐ Other _____

Medical History

Please check all that apply. ☐ Have you been hospitalized? ☐ Are you taking medication? ☐ Do you have allergies?

Please describe. _____

- ☐ *Pre-med – Amox
- ☐ *Pre-med – Clind
- ☐ *Pre-med – Other_____
- ☐ Allergy – Aspirin
- ☐ Allergy – Codeine
- ☐ Allergy – Erythro
- ☐ Allergy – Hay fever
- ☐ Allergy – Latex
- ☐ Allergy – Penicillin
- ☐ Allergy – Sulfa
- ☐ Allergy – Other _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial heart valve
- ☐ Artificial joints
- ☐ Asthma
- ☐ Back problems
- ☐ Biphosphonate meds (FosaMax, Acetol, Atelviz, Didronel, Boniva)
- ☐ Bleeding disorders
- ☐ Blood thinners
- ☐ Blood disease
- ☐ Blood transfusion
- ☐ Cancer _____
- ☐ Chemical or drug dependencies
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Cortisone treatment
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Head injuries
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Marijuana usage
- ☐ Mental disorders
- ☐ Mitral valve prolap
- ☐ Nervous disorders
- ☐ Nursing
- ☐ Pacemaker
- ☐ Persistent cough
- ☐ Pregnant
- ☐ Radiation treatment
- ☐ Respiratory problems
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Shortness of breath
- ☐ Stroke
- ☐ Swelling feet or ankles
- ☐ Taking birth control
- ☐ Thyroid condition
- ☐ Tobacco usage
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Other_____

Physician's Name _____ Physician's Phone _____ Pharmacy Name _____ Pharmacy Phone _____

For Females Only

Are you taking birth control medication or are on any other birth control system? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

If you are pregnant or if there is a chance you could be pregnant, please notify the office staff immediately. This applies to this appointment or any other future appointment.

To the best of my knowledge the above information is accurate and complete. I will not hold the doctor or any members of their staff responsible for any errors or omissions I may have made in the completion of this form.

Patient or Parent Signature _____ Patient Name _____ Date _____

Financial, Treatment Policy and Consent

Please read and ask questions if you do not understand, then sign this policy.

THANK YOU for choosing our office to provide your dental care. We appreciate your trust and look forward to working with you. In order to prevent any misunderstanding and to better serve you, we ask that all patients read and sign our **FINANCIAL POLICY**. If you have any questions, please ask to speak with the Office Manager.

As a courtesy to you, we will verify your insurance for eligibility and benefits prior to your initial visit as well as any time you notify us of a change in your coverage. We cannot guarantee that the information we receive is a guarantee of payment. Insurance companies state that coverage is only an **estimation** of benefits. You are ultimately responsible for knowing what your plan covers or does not cover and if there are waiting periods for work to be performed. Any amounts not covered by your plan, except for contractual fee discounts, are your financial responsibility.

Balances Due Per the Explanation of Benefits (EOB). After your insurance has processed the insurance claim, balances are due immediately upon receipt of a bill from this office. If you disagree with the amounts due per your EOB, it is not only your responsibility to contact the insurance company immediately for resolution of the problem, but also to pay any balances due to this office at that time pending the resolution of the problem with the insurance company.

New Insurance Information as well as **Changes in Insurance** must be provided to this office prior to any appointment. Failure to provide correct and current insurance information may result in the entire bill being your own responsibility.

Insurance Requests for Additional Information must be responded to immediately. This includes documentation of college student's full-time status, proof of continued enrollment in insurance plan (usually following open enrollment), and dual insurance verification. Failure to provide this information to the insurance company in a timely manner may result in the entire bill being your own responsibility. If your insurer denies coverage or delays payment beyond 60 days from the claim filing date, the entire amount will become due and payable by you. Although we make every effort to help you obtain your full benefit, there are many variables we can neither anticipate nor control. Please be aware that your insurance benefits are a contract between you, your employer (if applicable), and your insurance company.

Payment. Advantage Dentists is committed to providing you with the best dental care available. We have found that a clear understanding of our office financial guidelines helps relieve some of the anxiety associated with going to the dentist. We want to be certain that our guidelines are clear and that all of your questions are answered to your satisfaction. For your convenience we honor several different payment plans.

Payment Options. When you do not have dental insurance, we ask that you pay for your dental services in full at the end of each appointment. We gladly accept cash, MasterCard, Visa, Discover and American Express.

Financial Services. We offer CareCredit service that allows you to pay over time with convenient monthly payments. For more information please inquire with the front office staff. We also offer an in-house dental care membership plan for those without insurance as an added value to you.

Cancelling Treatment. We understand that sometimes a patient may find it necessary to cancel treatment that has not started or is not yet complete. If that treatment was paid in advance then you may be entitled to refund up to the full amount. In cases where treatment is in progress your prepayment will be reduced by the amount of work completed. If you only partially prepaid for this treatment, you could still have a balance due.

Refund Policy. As part of our fraud and abuse controls our office staff does not have the ability to directly issue a refund. They will submit a refund request to our Accounts Payable department on your behalf. In the event of Health Savings Accounts (HSAs) or third-party payors like CareCredit, refunds must be processed directly back to the originator and you will receive a credit on your account as opposed to a check in the mail. Our process, including internal controls, takes about two weeks to complete.

Statements are sent on monthly basis and as needed. You will need to remit payment by mail immediately upon receipt of a bill. You agree to contact the office immediately if you have any questions regarding a bill you may receive. Bills are not sent out only for informational purposes, but to notify you of payment expected from this office.

Financial, Treatment Policy and Consent

Balances That Exceed 90 Days. You understand that if you allow your account balance to exceed 90 days, you may receive a **Final Notice** letter. Failure to pay your account or arrange a payment plan within 10 days may result in your account being turned over to a collections agency. If this happens, a **Collection Fee** of 29% of the balance sent to the collection agency will be added to your account balance, and you will have to find another dentist within 30 days. You understand that the collection agency will report unpaid balances to the major credit bureaus, and this will remain on your credit report for 7 years. Before you can be seen in this office again, you understand that all fees must be paid. All billing of accounts 60 days overdue will carry an interest of 18% and a billing charge of $15 on every billing cycle.

Changes in Address or **Telephone Numbers** should be provided immediately as soon as a change occurs. You understand that if the office cannot contact you via telephone or mail about my outstanding balance, your account will be turned over to a collections agency for further collection activity.

Returned Checks will incur a $30 fee (or whatever the law allows). The amount of the check plus the fee must be paid within 10 days of notification by money order, cash, or credit card. You understand that the office will no longer accept personal checks for payment once a check is returned and no further treatment will be rendered until all owed amount is paid.

We do not treat our patients according to insurance companies' policies. If your insurance company decides not to cover a procedure, it will be your responsibility to pay the claim. We only treat you according to your dental needs, not according to insurance policies.

Changes made by insurance company on your benefits. This office is not responsible for changes made by your insurance company to the procedure code done and billed by our office. (*For example*: A certain procedure is done in this office and changed by your insurance company to a different procedure benefit or several procedures bundled into one benefit.)

We do not use silver (amalgam) filling in this office. If your insurance company changes any procedure done in this office to a silver filling code, you are responsible for the difference in price.

We take necessary radiographs for diagnosis reasons and to comply with the standard of care and the needs of the doctors for diagnosis. This office is not responsible if insurance denies a radiograph claim for any reason.

Cosmetic procedures are done in this office on a regular basis at the consent of patients. You are ultimately responsible for the balance if your insurance company determines the procedure unnecessary for cosmetic reason.

Assignment of benefits. We will file your insurance as a courtesy to you on the understanding benefits are a contract between you and your insurance, and in the event your insurance denies coverage or payment, you are ultimately responsible for the remaining balance. By signing this agreement, you (or any of your dependents) assign directly to this dental office and dentists all insurance benefits, otherwise payable to you as service rendered. You are also giving us authorization to release all information necessary to secure the payment of benefits. Your signature will be also used for all insurance submission.

Consent for treatment. This signature also serves as consent for basic treatment (cleaning, exam, radiographs, and application of fluoride, taking vital signs…). If you have any objection to any basic treatment, please notify us.

Please ask one or our team members if you have any other questions about our treatment and financial policies.

The office financial policy is subject to change, and fair changes will apply to all existing and new patients without notice or prejudice.

Video Surveillance. This facility is equipped with a video surveillance system. This is done for your protection and for the protection of this facility and its operators.

Photography. We take photos of all patients, and are used on a regular basis for diagnostic, teaching and some cases for marketing reasons. All privacy etiquettes are followed. If you have any questions or concerns, please talk to one of our team members. If you do not agree with this clause, please notify us.

Telephone calls. All telephone calls made to and out of this office may be recorded without prior notification.

Please sign below to acknowledge understanding of the entire financial policy.

Patient or Parent Signature	Patient Name	Date
_____	_____	_____

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

PROTECTING YOUR CONFIDENTIAL HEALTH INFORMATION IS IMPORTANT TO US!

OUR PROMISE!

Dear Patient:

This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA – Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

SO WHAT HAS CHANGED? WHY A PRIVACY POLICY NOW? VERY GOOD QUESTIONS!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare.

The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your **HEALTH INFORMATION** only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

HOW YOUR HEALTH INFORMATION MAY BE USED

TO PROVIDE TREATMENT

We will use your **HEALTH INFORMATION** within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing you services and/or treatment.

TO OBTAIN PAYMENT

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

TO CONDUCT HEALTH CARE OPERATIONS

Your health information may be used during performance evaluation of our staff. Some of our best teaching opportunities use clinical situation experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process and certification, licensing or credentialing activities.

IN PATIENT REMINDERS

Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and restorative care modern dentistry can provide. They may include postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

ABUSE OR NEGLECT

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

PUBLIC HEALTH AND NATIONAL SECURITY

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

FOR LAW ENFORCEMENT

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

FAMILY, FRIENDS AND CAREGIVERS

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medication, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Acknowledgement

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions, we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by your signature. We look forward to guiding you with your dental care.

PATIENT RIGHTS

This new law is careful to describe that you have the following rights related to your health information.

RESTRICTIONS

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our clients.

CONFIDENTIAL COMMUNICATIONS

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

INSPECT AND COPY YOUR HEALTH INFORMATION

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

AMEND YOUR HEALTH INFORMATION

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

DOCUMENTATION OF HEALTH INFORMATION

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

REQUEST A PAPER COPY OF THE NOTICE

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

Additional people to whom Advantage Dentists can release information:

_____

_____

Patient or Parent Signature _____ Patient Name _____ Date _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of all policies contained herein, but was unable to do so, as documented below:

Reason _____ *Initials* _____ *Date* _____

SUBMIT