# Hometown Dental of New Carlisle
## WELCOME TO OUR PRACTICE!

### PATIENT INFORMATION

DATE: ____/____/____ SOC. SEC. #: _____-_____-_____ DATE OF BIRTH: _____/_____/_____

NAME: _____ ☐ MALE ☐ FEMALE

(FIRST) (LAST) (MIDDLE INITIAL)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____

E-MAIL ADDRESS: _____

EMPLOYER: _____ WORK PHONE: _____

BUSINESS ADDRESS: _____ OCCUPATION: _____

WHOM MAY WE THANK FOR REFERRING YOU: _____

EMERGENCY CONTACT NAME: _____ PHONE: _____

☐ MINOR ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

### * IF A MINOR, RESPONSIBLE PARTY INFORMATION *

NAME: _____ ☐ MALE ☐ FEMALE

(FIRST) (LAST) (MIDDLE INITIAL)

SOC. SEC. #: _____-_____-_____ DATE OF BIRTH: ___/____/_____ RELATIONSHIP: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____

### PRIMARY INSURANCE INFORMATION

POLICY HOLDER NAME: _____

(FIRST) (LAST) (MIDDLE INITIAL)

SOC. SEC. #: _____-_____-_____ DATE OF BIRTH: ____/____/_____ ☐ MALE ☐ FEMALE

RELATIONSHIP TO PATIENT: _____ INS CO. NAME: _____

INS PHONE: _____ SUBSCRIBER ID: _____ GROUP #: _____

INS ADDRESS: _____

EMPLOYER: _____ EMPLOYER PHONE: _____

### SECONDARY INSURANCE INFORMATION

POLICY HOLDER NAME: _____

(FIRST) (LAST) (MIDDLE INITIAL)

SOC. SEC. #: _____-_____-_____ DATE OF BIRTH: ____/____/_____ ☐ MALE ☐ FEMALE

RELATIONSHIP TO PATIENT: _____ INS CO. NAME: _____

INS PHONE: _____ SUBSCRIBER ID: _____ GROUP #: _____

INS ADDRESS: _____

EMPLOYER: _____ EMPLOYER PHONE: _____

# MEDICAL HISTORY

**PATIENT'S NAME:** _____

1. **CURRENTLY UNDER MEDICAL CARE?** □ YES □ NO **EXPLAIN:** _____
2. **HISTORY OF SERIOUS ILNESS OR INJURY?** □ YES □ NO **EXPLAIN:** _____
3. **ARE YOU TAKING ANY MEDICATIONS?** □ YES □ NO **WHAT ARE THEY?** _____

_____

_____

4. **DO YOU USE ALCOHOL OR OTHER DRUGS?** □ YES □ NO 5. **DO YOU SMOKE?** □ YES □ NO

6. **ARE YOU PREGNANT?** □ YES □ NO 7. **ARE YOU NURSING?** □ YES □ NO 8. **DO YOU TAKE BIRTH CONTROL PILLS?** □ YES □ NO

9. **DO YOU TAKE OR HAVE YOU TAKEN BISPHOSPHONATES? (EX. FOSOMAX, DIDRONEL, ATELVIA, BONIVA)** □ YES □ NO

**ARE YOU ALLERGIC TO:** □ **PENICILLIN** □ **CODIENE** □ **NSAIDS** □ **LATEX** □ **LIDOCAINE**

10. **DO YOU HAVE ANY OTHER ALLERGIES?** □ YES □ NO **WHAT ARE THEY?** _____

_____

11. **HAVE YOU HAD ANY SURGERIES?** □ YES □ NO **EXPLAIN:** _____

_____

**PRE-MEDICATION NECESSARY?** □ YES □ NO

**CHECK ALL THAT APPLY**

| | | | |
|---|---|---|---|
| □ ABNORMAL BLEEDING | □ CONGENITAL HEART DISEASE | □ HIV POSITIVE | □RHEUMATIC FEVER |
| □ AIDS | □ CORTISONE TREATMENTS | □ JAUNDICE | □ SCARLET FEVER |
| □ ANEMIA | □ COUGH -PERSISTANT/BLOODY | □ JAW PAIN | □ SHORTNESS OF BREATH |
| □ ARTHRITIS, REHUMATISM | □DIABETES | □ KIDNEY DISEASE | □ SINUS TROUBLE |
| □ ARTIFICAL HEART VALVE | □EMPHYSEMA | □ LIVER DISEASE | □ SKIN RASH |
| □ ARTIFICAL JOINTS | □EPILEPSY | □ LOW BLOOD PRESSURE | □ STROKE |
| □ ASTHMA | □FAINTING OR DIZZINESS | □ MITRAL VALVE PROLAPSE | □ SWELLING OF FEET / ANKLE |
| □ BACK PROBLEMS | □GLAUCOMA | □ MONO | □ SWOLLEN NECK OR GLANDS |
| □ BLOOD DISEASE | □HEADACHES | □ MRSA | □ THYROID DISEASE |
| □ CANCER | □HEART MURMUR | □ NERVOUS PROBLEMS | □ TONSILITIS |
| □ CHEMICAL DEPENDENCY | □HEART PROBLEMS | □ PACEMAKER | □ TUBERCULOSIS |
| □ CHEMOTHERAY | □ HEPATITS TYPE _____ | □ PSYCHIATRIC CARE | □ TUMOR/GROWTH ON HEAD / NECK |
| □ CHRONIC FATIGUE | □ HERPES / COLD SORES | □ RADIATION TREATMENT | □ ULCERS / COLITIS |
| □ CIRCULATORY PROBLEMS | □ HIGH BLOOD PRESSURE | □ RESPIRATORY DISEASE | □VENEREAL DISEASE |

□ OTHER **EXPLAIN:** _____

## ASSIGNMENT AND RELEASE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO **HOMETOWN DENTAL OF NEW CARLISLE** FOR ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY INSURANCE, AND FOR ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

I AUTHORIZE THE ABOVE DOCTOR AND/OR ANY PROVIDER, CORPORATION, OR SUPPLIER OF SERVICES IN THIS OFFICE TO RELEASE THE INFORMATION REQUIRED TO SECURE THE PAYMENT OF BENEFITS.I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

**SIGNATURE OF RESPONSIBLE PARTY:** _____ **DATE:** _____/_____/_____

HOMETOWN DENTAL

# Financial Policy

**Insurance:** Insurance is a contract between you and your insurance company. We are ***NOT*** a party to this contract. We will verify and file your insurance claim as a courtesy to you. ***Although we may estimate what your insurance may pay, it is the insurance that makes the final determination of your eligibility. We do NOT guarantee the accuracy of any estimate of benefits relating to the patient's plan or rendered treatment. You are responsible for payment of any portion of the charges not covered by your insurance.*** Benefits are payable in accordance with the coverage in effect at the time treatment is rendered, and are subject to plan maximums, deductibles, co-insurance factors and any other specific plan limitations. It is your full responsibility to understand the terms and payments at the time treatment is rendered.

Payment for services is due at the time of treatment by one of the following:

- Cash
- Debit/credit card
- Checks
- Care Credit (a monthly payment plan that requires prior credit approval).

**Monthly Statement:** If you have a balance on your account for any reason, we will send you a monthly statement. The balance on your statement is due and payable by the indicated due date and will be considered past due if not paid by such time.

**Past Due Accounts:** If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you may also be assessed a collection fee.

***I have read, understand, and agree with the above policy.***

Patient's Name: _____

Responsible Party (If not Patient): _____

Signature: _____ Date: _____

# Hometown Dental of New Carlisle

## PAYMENT POLICY

At Hometown Dental of New Carlisle, we pride ourselves in offering the best quality of care to our patients, and as a courtesy we go over pre-treatment estimates as well as submit claims on our patient's behalf. **Please note that insurance companies have ever changing regulations, benefits, deductibles, downgrade charges and allowable fees that unfortunately, only allows our office to estimate a patients' co-payment.** Please also keep in mind that the dental insurance contract is between the insurance company and the patient, and after our office receives payments from the insurance company for treatments rendered anything remaining is the patient's responsibility. **Co-Payments must be paid AT THE TIME OF SERVICE and if you have an account balance, we will expect that you come prepared to pay that balance along with your co-payment. There will be a $35.00 processing fee for any and all returned or bounced checks and you will no longer be able to use this payment method in the future.** The treatment recommended by our office is never based on what your insurance will pay but the treatment that we feel is in your best interest. Please take the time to thoroughly review your dental contract so that our office can best serve you. If you do have any questions or concerns in regards to your insurance company or benefits, our front office staff is always available to help clarify to the best of our abilities your services, billing and insurance questions. **Please notify our office PRIOR to any dental appointments if there are any dental insurance changes for yourself and/or family. Thank you!**

**Patient Name:** _____ **Date:** ____/____/_____

**Patient/Parent/Guardian Signature:** _____

## APPOINTMENT POLICY

At Hometown Dental of New Carlisle, our staff prides ourselves on offering the best quality of care to our patients, and as a courtesy we offer several appointment reminders. **As a courtesy to our office we do ask that you confirm every appointment so that we can best serve our patients' needs. If for any reason you do need to cancel / reschedule an appointment our office does require TWO DAY'S NOTICE to do so or you could be subject to a $25.00 charge PER hour of scheduled appointment, be placed on a same day appointment basis, or possible dismissal from the practice.** If at any time you do need to cancel or reschedule your appointment and our office is closed, or our office staff is assisting with other patient's and you are unable to get ahold of us you can always leave a message on our answering service which is checked several times throughout the day. If you have any questions or concerns regarding our office policy our front office staff is always available to clarify any questions you may have. Thank you!

**Patient Name:** _____ **Date:** ____/____/_____

**Patient/Parent/Guardian Signature:** _____

# Hometown Dental of New Carlisle

## ACKNOWLEDGMENT OF HIPAA PRIVACY POLICY

At Hometown Dental of New Carlisle we pride ourselves in respecting and following our patients' HIPAA privacy rights, which states that unless directed to by our patient we are unable to give any personal information including but not limited to treatment inquiries, financial inquiries, changing/canceling and/or rescheduling appointments as well as giving out any personal account information to another other than the patient, unless we need to refer to a specialist. **If there is anyone that you would like to have access to your account, financial status, scheduling and/or treatment with our office please make notation of this person as well as their relationship to the patient below.**

I give _____ access to make/cancel appointments on my behalf when I am unable to do so, as well as take messages from Hometown Dental of New Carlisle.

Relationship to Patient: _____

I give _____ access to my treatment plans as well as my financial standings and account balances with Hometown Dental of New Carlisle.

Relationship to Patient: _____

Patient/Parent/Guardian Signature: _____

Date: _____/_____/_____

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For Office Use Only

_____ Individual Refused to Sign

_____ Communication Barriers Prohibited Obtaining Acknowledgment

_____ An Emergency Situation Prevented Us From Obtaining Acknowledgment

_____ Other (Please Specify) _____