GREENE & RATCLIFF
FAMILY & COSMETIC DENTISTRY

PATIENT INTAKE FORM

Disclaimer: This form is used to collect information about new patients and used for internal purposes only. The information you supply is confidential and will be treated accordingly.

PATIENT DETAILS

Preferred Name: _____

First Name: _____ **Last Name**: _____
Date of Birth: _____ **Gender**: ☐ Male ☐ Female ☐ Other
Street Address: _____
City: _____ **State**: _____ **ZIP Code**: _____
Home Phone: _____ **Mobile Phone**: _____
Social Security Number: _____ **E-Mail**: _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Spouse Name: _____ **Spouse Phone**: _____

PRIMARY DENTAL INSURANCE POLICY

Employer: _____

Primary Insurance Company: _____
Group #: _____ **ID #**: _____
Primary Insurance Type: ☐ HMO ☐ PPO ☐ Medicare ☐ Other: _____
Complete the following if you are ***not*** the policyholder for your primary insurance:
Insurance Policyholder: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _____
Policyholder Name: _____ **Date of Birth**: _____
Policyholder Social Security Number: _____

SECONDARY DENTAL INS POLICY (IF ANY)

Employer: _____

Secondary Insurance Company: _____
Group #: _____ **ID #**: _____
Primary Insurance Type: ☐ HMO ☐ PPO ☐ Medicare ☐ Other: _____
Complete the following if you are ***not*** the policyholder for your secondary insurance:
Insurance Policyholder: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _____
Policyholder Name: _____ **Date of Birth**: _____
Policyholder Social Security Number: _____

EMERGENCY CONTACT

Emergency Contact Name: _____
Relationship: _____ **E-Mail**: _____
Home Phone: _____ **Mobile Phone**: _____

How did you hear about us? Who referred you to our practice? _____

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TREATING PHYSICIANS

Primary Care Physician: _____ **Phone**: _____
List all other active treating physicians:

Physician Name: _____ **Specialty**: _____
Physician Name: _____ **Specialty**: _____
Physician Name: _____ **Specialty**: _____
Physician Name: _____ **Specialty**: _____

ALLERGIES

List your allergies and describe the reactions to your body:

Allergy: _____ **Reaction**: _____
Allergy: _____ **Reaction**: _____
Allergy: _____ **Reaction**: _____
Allergy: _____ **Reaction**: _____
Allergy: _____ **Reaction**: _____

MEDICATION

List the medications you are currently taking including the dosage:

Medication: _____ **Dose**: _____
Medication: _____ **Dose**: _____
Medication: _____ **Dose**: _____
Medication: _____ **Dose**: _____
Medication: _____ **Dose**: _____
Medication: _____ **Dose**: _____
Medication: _____ **Dose**: _____
Medication: _____ **Dose**: _____

PREFERRED PHARMACY

Pharmacy Name: _____ **Phone**: _____
Street Address: _____
City: _____ **State**: _____ **ZIP Code**: _____

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SURGICAL HISTORY

List any surgeries, fractures, major illnesses, or hospitalizations that you have had:

DESCRIPTION	DOCTOR	LOCATION	DATE

SOCIAL HISTORY

Do you currently consume alcohol? ☐ Yes ☐ No

• How many drinks per week? _____

Do you currently smoke? ☐ Yes ☐ No

- What do you smoke? ☐ Tobacco ☐ Marijuana ☐ Other: _____
- How many cigarettes do you smoke per day? _____

Complete the following if applicable:

Are you pregnant now? ☐ Yes ☐ No

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MEDICAL HISTORY

Have you ever had any of the following? Please mark Yes or No

	Y	N
Anemia		
Arthritis		
Asthma		
Atrial Fibrillation		
Bleeding Problems		
Coronary Artery Disease		
Cancer		
Cardiac Arrest		
Celiac Disease		
Chest Pain		
Congestive Heart Failure		
Chronic Fatigue Syndrome		
Depression		
Diabetes		
Drug/Alcohol Abuse		
Fibromyalgia		
Gerd		
Heart Disease		
Hyperinsulinemia		
Hyperlipidemia		

	Y	N
Hypertension		
Hypothyroidism		
Migraines/Headaches		
Neuropathy		
Osteoporosis		
Pulmonary Embolism		
Seizure Disorders		
Shortness of Breath		
Sinus Conditions		
Stroke		
Tremors		
Artificial joint		
Do you require antibiotics for dental visits?		

List any other medical problems that you have had:

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PATIENT CONSENT

By signing below, I hereby acknowledge, agree, and authorize all of the following:

1. a) **Accurate Information**. I certify that the information provided on this form is accurate, complete, and up to date to the best of my knowledge.
2. b) **Patient Rights and Responsibilities**. I understand that the healthcare facility maintains a Notice of Privacy Practices, which describes how my protected health information may be used and disclosed, and how I may access my health records. I understand that I have the right to review this healthcare facility's Notice of Privacy Practices prior to signing this form.
3. c) **Release of Medical Information**. I authorize the release of my health information to the healthcare facility in accordance with the healthcare facility's Notice of Privacy Practices. This includes, but is not limited to, releasing medical information to my referring physician, primary care physician, and any physician(s) I may be referred to. The healthcare facility shall ensure all health information remains confidential, as required by HIPAA, and will not release any of my health information without my consent.
4. d) **Consent for Treatment**. I grant the healthcare facility, including its affiliated providers, physicians, and other medical personnel, permission to use the health information provided for the purpose of my medical treatment as necessary.
5. e) **Consent to Communication**. I consent to receiving communications from the healthcare facility regarding appointment reminders, test results, and other necessary healthcare-related information via phone, email, or channels.
6. f) **Acknowledgment**. By signing below, I hereby acknowledge, agree, and authorize all of the above, and I authorize the healthcare facility to retrieve and review my medical history and authorize the healthcare facility to release the information required in obtaining procedure authorization or the processing of any insurance claims.

Patient Signature: _____ **Date**: _____

Print Name: _____

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Financial Policy

The following is our financial policy, please read and sign prior to treatment. If you have questions or concerns we will be happy to assist you.

IF YOU HAVE INSURANCE: We will verify your insurance eligibility and file your claim for you. However, the estimated portion not covered by your plan is due at the time of service. We will estimate your portion of the fees based on the information we receive from your insurance company. Insurance companies state " this is not a guarantee of payment". In the event your insurance company does not pay the balance for services rendered, payment for any remaining balance is due and payable by you. If your estimated portion exceeds the fee for services rendered, creating a credit balance, a refund will be immediately issued to you.

Understanding insurance: Insurance is filed as a courtesy to you and coverage does not relieve the patient or guarantor of financial responsibility. Your insurance benefits are negotiated between your employer and the insurance company. We are not a part of those negotiations.

If you have questions regarding your dental plan or a problem with a reimbursement level, contact your employer insurance company. Plans offered by the same employer or written by the same third-party payer can vary according to the contracts involved.

If you do not have insurance: Our fee for services will be due and payable in full on the date services are rendered. We accept Cash, Checks (with proper ID), Visa, MasterCard, American Express and Discover. Our office does not finance treatment plans, however, we do offer (upon a credit approval) payment plans through Care Credit which has a no interest option and/or fixed interest for long term payouts. We will be happy to discuss this option with you.

After 60 days any unpaid balance may be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to a collection agency, the client or responsible party agrees to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys fees, we incur in such collection efforts.

I have read and understand the financial policy. I understand I am responsible for all the fees for services rendered, regardless of insurance coverage.

_____ Date_____

Print Name of Responsible Party

_____ Signature of Responsible Party

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

_____ _____

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 Surname ☐ 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