Village Dental
COSMETIC & GENERAL DENTISTRY

Patient Information

Name: _____ **Preferred Name:** _____ **Gender:** Male / Female
Date of Birth: ____ / ____ / _____ SSN#: _____ **Family Status:** Single / Married / Child
Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Phone: _____ Mobile / Home / Work
Phone: _____ Mobile / Home / Work
Email: _____
Preferred method of communication: Text / Email / Call Mobile / Call Home / Call Work
How did you find our practice? Google / Post Card / Facebook / Yelp / Insurance / Family / Friend
Who can we thank for referring you? _____

In the event of an emergency, whom should we contact?
Name: _____ Relationship: _____ Phone #: _____

Person Responsible for Account (*If different from patient*)

Name of Responsible Party: _____
Date of Birth: ___ / ___ / ____ **SSN#:** _____
Relationship to Patient: Self / Spouse / Parent / Other: _____
Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Phone: _____ Mobile / Home / Work
Email: _____

Primary Dental Insurance Information

Subscriber Name: _____ **Subscriber SSN:** _____
Subscriber Date of Birth: ___ / ___ / _____ **Relationship:** Self / Spouse / Parent
Subscriber Employer: _____ **Subscriber Zip Code:** _____
Insurance Name: _____ **Phone:** _____
Member ID: _____ **Group #:** _____

Secondary Dental Insurance Information

Subscriber Name: _____ **Subscriber SSN:** _____
Subscriber Date of Birth: ___ / ___ / _____ **Relationship:** Self / Spouse / Parent
Subscriber Employer: _____ **Subscriber Zip Code:** _____
Insurance Name: _____ **Phone:** _____
Member ID: _____ **Group #:** _____

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Dental History

Previous Dental office: _____ **City:**_____
Date of most recent exam: _____ **Date of most recent x-rays:** _____
Is there anything you would like addressed during your appointment? Yes / No
If yes, please specify: _____

Medical History

Are you currently under any medical treatment? Yes / No
If yes, please specify: _____
Have you ever experienced excessive bleeding requiring special treatment? Yes / No
WOMEN, please mark if you are currently: Pregnant / Trying to get pregnant / Breast Feeding
Have you been told to pre-medicate with antibiotics prior to a dental appointment? Yes / No
Have you previously taken bisphosphonates (e.g. Fosamax)? Yes / No
Are you allergic to *or* have you had an allergic reaction to any of the following?

- ☐ Acrylic
- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Erythromycin
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Metals
- ☐ Penicillin
- ☐ Sedatives
- ☐ Other _____

Have you ever experienced any of the following?

- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Implant
- ☐ Asthma
- ☐ Cancer
- ☐ Cardiac Pacemaker
- ☐ Cold Sore
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Heart Disease
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ HIV+, AIDS, STDs
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Radiation Treatment
- ☐ Sinus Problem
- ☐ Stroke
- ☐ Tobacco Use
- ☐ Transplant
- ☐ Other _____

Please list any medications you are currently taking (a list may be attached instead):
_____

I acknowledge the importance of an accurate medical history. Incomplete information may have an adverse effect on my dental and overall health. The information above is complete and correct.

Signature: _____ Date: _____

Acknowledgement of Privacy Practices & Permission to Release Protected Health Information

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with a notice of The Health Insurance Portability and Accountability Act (HIPAA) and our offices Notice of Privacy Practices. *Our Notice is available online.* If you prefer a paper copy, please ask a member of our team.

I understand that my personal and health information is private, protected by Village Dental, and will not be shared with anyone without written consent. I give permission for the office of Village Dental to release my protected health information, such as: pending or completed treatment, insurance, medical history, account, and appointment information *to other dental and health care professionals,* ***and the following individuals***:

Name: _____ **Relationship:** _____
Name: _____ **Relationship:** _____
Name: _____ **Relationship:** _____
Name: _____ **Relationship:** _____

Signature: _____ Date: _____

Cancellations and Missed Appointments

Your time commitment is very important to us, and all appointment times are reserved specifically for you. ***48 hours advanced notice*** is required to change any appointment. If you are not able to provide adequate notice to cancel or reschedule, a fee of $50.00 will be charged to your account. Patients who fail to present for multiple appointments may be dismissed from the practice.

I acknowledge that I have read and understand the Cancellation and Missed Appointments policy.

Signature: _____ Date: _____

Financial Agreement

Payment for treatment is due the day services are rendered, regardless of insurance coverage. **We provide treatment cost <u>estimations</u> only; we do not guarantee any payment from your insurance company.** Several payment methods are accepted, including cash, check, major credit cards, and CareCredit. Should you need a more flexible payment option, our admin team can assist in finding the appropriate financial arrangement prior to your appointment date.

As a courtesy, we will bill your dental insurance on your behalf for services rendered. We participate with many dental insurance companies as a PPO provider. Your insurance plan is a contract between you and your insurance company; we are not a party in your contract. It is your responsibility to read and understand your coverage, and notify us of any changes to your insurance policy.

Treatment recommendations, and services provided are in the best interest of your health and *will not be determined based on insurance coverage*. We strive to provide accurate information and estimations regarding treatment plan fees, insurance coverages, and payment amounts. Insurance claim payments are typically received 4-6 weeks after the date of service, and final payment amounts may vary from the estimate initially presented.

You are responsible for the entirety of your bill, **even if the amount remitted by insurance is less than the initial *estimated* amount.** If a balance remains or if your insurance provider neglects to pay, you are responsible for the total balance of the services rendered. We will make every attempt to notify you of account balances in a timely manner. It is your responsibility to maintain current contact information so that we may do so.

We utilize a third-party financial service agency ***after <u>all</u> contact methods have been exhausted*** with no acquisition of payment. In the event that your account is assigned to collections, the following will apply:

- The collection agency will charge a commission or fee that may be as much as 50% of the amount owed to Village Dental.
- Village Dental may add the amount of the collection agency's commission or fee to the amount owed, and you agree to pay the additional amount. The addition of a collection agency's fee or commission to an unpaid balance may result in your owing a sum substantially more than the amount owed for dental services. For example, if the unpaid balance owed to Village Dental is $1000, Village Dental may add up to $500 to your account, and you agree to pay the sum of $1500 in such event.
- In the event legal action is commenced to enforce monetary obligations hereunder, it is your responsibility to pay court costs and reasonable attorney's fee.

I acknowledge and accept the guidelines as outlined in the above Financial Agreement.

Signature: _____ Date: _____