Patient Information Form

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT

Name ______________________________ Birthdate ___/___/___
Last First Nickname(Preferred Name) MI M D Y

SS# ____________ ☐ Female ☐ Male Driver's License # ____________ Age ______

Mailing Address ______________________________ Home# ____________
Street/PO Box Apt/Unit# City State Zip

Employer Name ____________ Occupation ____________ Work# ____________

Special interests, sports, or hobbies ______________________________ Other# ____________

Who may we thank for referring you? ☐ Family/Friend ____________ ☐ Location ☐ Phonebook ☐ Website ____________
Name Other Family Seen By Us

SPOUSE OR GUARDIAN INFORMATION

Name ______________________________ Birthdate ___/___/___
Last First Nickname(Preferred Name) MI M D Y

SS# ____________ ☐ Female ☐ Male Driver's License # ____________ Age ______

Mailing Address ______________________________ Home# ____________
Street/PO Box Apt/Unit# City State Zip

Employer Name ____________ Occupation ____________ Work# ____________

PERSON RESPONSIBLE for Account (if patient is a minor) ***MUST BE PRESENT***

Name ______________________________ Birthdate ___/___/___
Last First Nickname(Preferred Name) MI M D Y

SS# ____________ ☐ Female ☐ Male Driver's License # ____________ Age ______

Mailing Address ______________________________ Home# ____________
Street/PO Box Apt/Unit# City State Zip

Employer Name ____________ Work# ____________ Relation To Patient ____________

EMERGENCY INFORMATION (Relative not living with you)

Phone# ____________

Name ____________ Address ______________________________
Street/PO Box City State Zip

INSURANCE INFORMATION

PRIMARY Insurance Company	**Address Street City State Zip**		**Phone Number** ( )	
Name of Member	**Relation to Patient**	**ID or SS#**	**Member Birthdate**	**Group Number**
SECONDARY Insurance Company	**Address Street City State Zip**		**Phone Number** ( )	
Name of Member	**Relation to Patient**	**ID or SS#**	**Member Birthdate**	**Group Number**

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if patient is a minor) ______________________________

Family First Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, ____, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

____

____

____

Family First Dentistry

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ………..

Address: ………

Telephone: …………………………………………………. E-mail: ……………………………………………………………………

Patient#: **N/A** Social Security#: **N/A**

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: ***Kelly Darling***

Telephone: *(907)562-2820* Fax: *(907)562-6781*

E-mail: *familyfirstdentistry@hotmail.com*

Address: *4050 Lake Otis, Suite 210, Anchorage, AK 99508*

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ………………………………………………………………, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: ……………………………………………………………………………………… Date: …………………………………...

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative Name: ………………………………………………………………………………………………

Relationship to Patient: ………………………………………………………………………………………………………..

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

Family First Dentistry Policy

Thank you for choosing *Family First Dentistry* as your dental healthcare provider. We are committed to providing you with the highest standard of total dental care. We consider payment of your bill as part of this care.

PAYMENTS

PAYMENT IS EXPECTED IN FULL, AT TIME OF SERVICE. This includes patientsø estimated portion not covered by an insurance company. If your insurance issues payment to the subscriber (rather than the provider, Family First Dentistry), you will need to pay in full at time of service.

We accept cash, checks, Visa, MasterCard, Discover and American Express in addition to Care Credit and Chase Health Advance.

Payments in full for treatment plans of $1,000.00 or more on or before treatment date will be given a discount of 10% for cash/check. We also offer a 10% military discount and a 10% senior discount for age 62 or older.

Our financial coordinator is available to discuss any questions regarding ways to help you with your financial considerations. It is your responsibility to have this conversation prior to receiving dental work.

INITIAL _______

INSURANCE

As a courtesy, Family First Dentistry will issue a bill to your dental insurance on your behalf. We accept assignment of **most** insurance benefits. **However, you are ultimately responsible for your total bill regardless of the outcome with your insurance company.** We will not become involved in disputes between you and your insurance company regarding deductibles, covered charges & õusual and customary fees,ö other than to provide factual information as necessary.

Therefore, at the end of 90 days from the date of service if we have not received payment in full from your insurance company you will be required to pay the remaining balance. There will be a 10.8% annual interest charge on any remaining balances after 90 days.

INITIAL _______

MISSED APPOINTMENTS

Please help us to serve you better by keeping your scheduled appointments. **We require a 24 hour notice of any changes made for an appointment that is up to one hour in length, and a 48 hour notice of any changes for appointments that exceed one hour.** It is important we receive this notice otherwise a **CANCELLATION FEE** will be charged to your account. The fee for up to a one hour appointment will be charged at a flat rate of **$45.00**. For appointments over one hour, the fee will be **20%** of the total charge for the work scheduled.

We are aware that at times there may be extenuating circumstances that will not allow the required notice.

INITIAL _______

MINOR PATIENTS

Either a parent or guardian must accompany anyone under 18 years of age. This person will be responsible for any payments.

INITIAL _______

X____

Signature of patient or responsible party Date

Health Questionnaire

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

Please answer each question. Circle **Yes** or **No** where applicable. Example: Are you alive? .... (YES) NO

MEDICAL HISTORY

1. Are you in good health? .... YES NO
2. Date of your last physical examination ________ Physicians Name ________
3. Are you now under the care of a physician? .... YES NO
   If so, what is the condition being treated? ________
4. Have you ever had any serious illness or operation? .... YES NO
   If so, what illness or operation? ________
5. Have you ever been hospitalized? .... YES NO
   If so, what was the problem? ________
6. Are you taking any medicine? ❑ Yes ❑ No or any recreational drugs (marijuana, cocaine, etc.?) .... YES NO
   If so, what? ________ What dosage? ________
7. Have you ever been pre-medicated with antibiotics for your dental treatment? .... YES NO
8. Are you sensitive or allergic to any drugs? ❑ Penicillin; ❑ Tetracycline; ❑ Sulfa Drugs; ❑ Aspirin; ❑ Codeine;
   ❑ Other If other, what drugs? ________ YES NO
9. Do you have or have you had any of the following: (Please **X** know conditions)

❑ Anemia	❑ Cold Sores	❑ Sinus Trouble	❑ Blood Transfusion	❑ Pain in Jaw Joints	❑ X-Ray or Cobalt Treatment
❑ Herpes	❑ Hemophilia	❑ Blood Disease	❑ Joint Replacement	❑ Respiratory Disease	❑ Fainting Spells or Seizures
❑ Stroke	❑ Rheumatism	❑ Drug Addiction	❑ Nervous Disorders	❑ Sickle Cell Disease	❑ Chemotherapy (Cancer, Leukemia)
❑ Ulcers	❑ Heart Murmur	❑ Kidney Disease	❑ Tumors or Growths	❑ Tuberculosis (T.B.)	❑ Radiation Treatment of any kind
❑ Diabetes	❑ Bruise Easily	❑ Stomach Ulcers	❑ Allergies or Hives	❑ Epilepsy or Seizure	❑ Hepatitis or Jaundice
❑ Glaucoma	❑ Head Injuries	❑ Angina Pectoris	❑ Cortisone Medicine	❑ Artificial Prosthesis	❑ Venereal Disease (Syphilis, Gonorrhea)
❑ Arthritis	❑ Heart Failure	❑ Mental Disorder	❑ Excessive Bleeding	❑ Psychiatric Treatment	❑ Acquired Immune Deficiency Syndrome/AIDS
❑ Emphysema	❑ Liver Disease	❑ Rheumatic Fever	❑ Asthma	❑ Congenital Heart Lesions	❑ TMJ (Temporomandibular joint)
❑ Hay Fever	❑ Scarlet Fever	❑ Thyroid Disease	❑ High Blood Pressure	❑ Difficulty in Swallowing	❑ Ever Used Phen Phen?
❑ Tonsillitis	❑ Chicken Pox	❑ Cerebral Palsy	❑ AIDS Related Complex	❑ Heart Ailments or Attack	❑ Other ________

10. Do you wear a cardiac pacemaker, or have you had heart surgery? .... YES NO
11. Do you have any disease, condition or problem not listed that you think I should know about? .... YES NO
    If so, what? ________
12. Do you smoke? If yes, how much? ______ per day .... YES NO
13. (Women) Are you pregnant? If so, how many months? ______ .... YES NO
14. (Women) Do you take birth control pills? .... YES NO

Dental History

1. Have you ever had a local anesthetic (Novocaine, etc.?) .... YES NO
2. Have you ever had any unfavorable reaction from a local anesthetic? .... YES NO
3. Have you ever had any serious trouble associated with any previous dental treatment? .... YES NO
   If so, explain ________
4. How long since your last full mouth X-Rays? ________
5. How long since your last dental treatment? ________
6. Does dental treatment make you nervous? .... YES NO
7. Would you desire to be pre-sedated? .... YES NO

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

Date ________ Signature ________

Year 2
Changes in Health
Date ________ Signature ________

Year 3
Changes in Health
Date ________ Signature ________

HEALTH QUESTIONNAIRE MUST BE UPDATED EVERY YEAR!

Reviewed By ________

Year 1 ________

Year 2 ________

Year 3

DO NOT WRITE IN THIS SPACE

	Year 1	**Year 2**	**Year 3**
Date			
BP	/	/	/
Pulse			
Temp			
By			

CONSENT FOR TREATMENT: I Hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of hte procedures, anesthetics and/or drugs.

I authorize my insurance company to issue the dental benefits of my plan directly to this office. I also authorize release of any information necessary to process dental insurance.

All services are rendered and accepted under the trems and condidtions printed on the reverse hereof.

Signature (Parent's signature if patient is a minor) ________ Date ________

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Family First Dentistry

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.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect **April 14, 2003**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using your professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you **$00.00** for each page, **$00.00** per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web side or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: ***Kelly Darling***

Telephone: *(907)562-2820* Fax: *(907)562-6781*

E-mail: *familyfirstdentistry@hotmail.com*

Address: *4050 Lake Otis, Suite 210, Anchorage, AK 99508*

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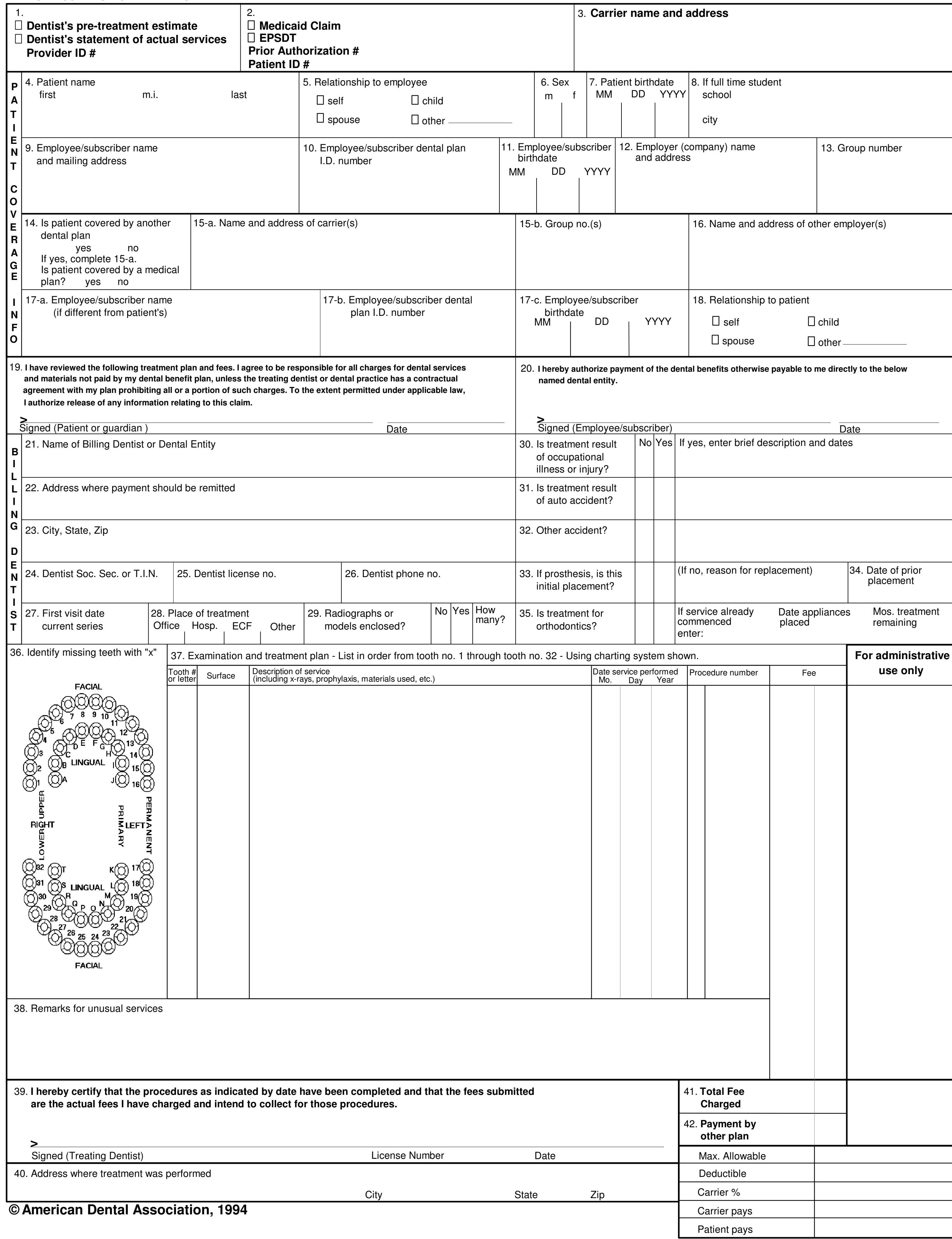
This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

Dental Claim Form



1.
☐ Dentist's pre-treatment estimate
☐ Dentist's statement of actual services
Provider ID #

2.
☐ Medicaid Claim
☐ EPSDT
Prior Authorization #
Patient ID #

3. **Carrier name and address**

PATIENT COVERAGE INFO

4. Patient name
first m.i. last

5. Relationship to employee
☐ self ☐ child
☐ spouse ☐ other

6. Sex
m f

7. Patient birthdate
MM DD YYYY

8. If full time student
school
city

9. Employee/subscriber name and mailing address

10. Employee/subscriber dental plan I.D. number

11. Employee/subscriber birthdate
MM DD YYYY

12. Employer (company) name and address

13. Group number

14. Is patient covered by another dental plan
yes no
If yes, complete 15-a.
Is patient covered by a medical plan? yes no

15-a. Name and address of carrier(s)

15-b. Group no.(s)

16. Name and address of other employer(s)

17-a. Employee/subscriber name (if different from patient's)

17-b. Employee/subscriber dental plan I.D. number

17-c. Employee/subscriber birthdate
MM DD YYYY

18. Relationship to patient
☐ self ☐ child
☐ spouse ☐ other

19. **I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.**

> Signed (Patient or guardian) Date

20. **I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.**

> Signed (Employee/subscriber) Date

BILLING DENTIST

21. Name of Billing Dentist or Dental Entity

22. Address where payment should be remitted

23. City, State, Zip

24. Dentist Soc. Sec. or T.I.N.

25. Dentist license no.

26. Dentist phone no.

27. First visit date current series

28. Place of treatment
Office Hosp. ECF Other

29. Radiographs or models enclosed? No Yes How many?

	No	Yes	If yes, enter brief description and dates
30. Is treatment result of occupational illness or injury?			
31. Is treatment result of auto accident?			
32. Other accident?			
33. If prosthesis, is this initial placement?			(If no, reason for replacement) — 34. Date of prior placement
35. Is treatment for orthodontics?			If service already commenced enter: — Date appliances placed — Mos. treatment remaining

36. Identify missing teeth with "x"

37. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Using charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo.	Day	Year	Procedure number	Fee

For administrative use only

38. Remarks for unusual services

39. **I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.**

> Signed (Treating Dentist) License Number Date

40. Address where treatment was performed
City State Zip

41. **Total Fee Charged**

42. **Payment by other plan**

Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

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