airadental

Patient Form

Name: _____ Date:_____

Date Of Birth: _____ SS#_____ Male _____ Female_____

Address: _____ City: _____ State:____

Zip: _____ Phone Number: (_____) _____-_____

Responsible Party/Parent or Guardian Information

Name: _____ Relationship _____

Home Phone # (_____) _____-_____ Cell Phone # (_____) _____-_____

Email: _____

Who is responsible for making appointment: _____

Emergency Contact Information

Name: _____ Address: _____

Relationship: _____ Home Phone # (____) _____-_____

Cell Phone # (_____) _____-_____

Primary Dental Insurance

Employer:_____ Phone #_____

Insurance Company_____ Group # _____

Insurance Company Address:_____ City: _____

State:_____ Zip:_____

Additional Dental Insurance

Policy Holder Name:_____ DOB: _____ SS# _____

Employer: _____ Phone # _____

Insurance Company: _____ Group # _____

Insurance Company Address: _____City: _____ State: _____Zip: _____

Medical History

Patient Name: _____ **Birth Date:** ____/____/____**Today's Date:** ____/____/____

Are you currently under the care of a physician? Yes _____ No _____ If yes, please explain:

_____

Are you taking any medications, pills, or drugs? Yes _____ No _____

If yes, please list medication, dosage, and frequency _____
_____
_____
_____

Do you need to pre-medicate for any conditions? Yes _____ No _____

Do you have, or have you had, any of the following? (Circle "Yes" or "No")

Yes No AIDS/HIV positive
Yes No Alzheimer's Disease
Yes No Anemia
Yes No Arthritis
Yes No Artificial Heart Valve
Yes No Artificial Joint
Yes No Asthma
Yes No Blood Disease
Yes No Bleeding Abnormally
Yes No Blood Thinner
Yes No Cancer
Yes No Chemotherapy
Yes No Cold Sores/Fever Blisters
Yes No Congenital Heart Disorder
Yes No Cortisone Treatment
Yes No Diabetes
Yes No Emphysema
Yes No Do you take Dialysis?
If yes, which days? (Circle) M T W TH F
Yes No Epilepsy or Seizures
Yes No Fainting/Dizziness
Yes No Heart Attack/Failure
Yes No Heart Murmur
Yes No Hepatitis A
Yes No Hepatitis B or C
Yes No Herpes
Yes No High Blood Pressure
Yes No Mitral Valve Prolapse
Yes No Mental/Psychiatric Care
Yes No Pacemaker
Yes No Radiation Treatments
Yes No Respiratory Disease
Yes No Stroke
Yes No Thyroid Disease
Yes No Tuberculosis
Yes No Tumors or Growths
Yes No Venereal Disease

Do you have or have you ever had any serious illness not listed above? If yes, please explain:

_____

Additional information you like for our doctors to know: _____

Please Circle Allergies: (Circle)

Penicillin Sulfa Codeine Latex Local Anesthetics Other _____

Women: Are you pregnant? Yes_____ No _____ Due Date_____
Are you nursing? Yes _____ No _____

Financial Consent For Treatment

I authorize the release of information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I understand that I am financially responsible for all charges whether or not paid by the insurance company. I also hereby assign payment of insurance to Aira Dental, otherwise payable to me, for services rendered.

X_____ **Date: ____/____/_____**

Broken Appointment Policy

Our office makes every effort to provide appointments that are convenient for you and your schedule. Broken appointments cause unnecessary scheduling problems and interfere with the timely completion of your dental procedures. Once established as a patient at our practice, we allow three (3) broken appointments. A broken appointment is defined as failure to show up for a confirmed appointment or an appointment that is cancelled with less than 24 hour notice. Once three broken appointments have occurred, we reserve the right to dismiss you from the practice.

Your signature below serves as confirmation that you fully understand our policies for cancellations, confirmations, and broken appointments.

X_____ Date _____/_____/_____

Cancellation Policy

Aira Dental's mission is to provide the best dental care possible for our patients. As an effort to provide this care we ask that all patients **arrive at least 10-15 minutes early** for their appointments. New patients are asked to **arrive 15-20 before** their scheduled appointment time to fill out new patient forms and allow time for **courtesy** insurance verifications. Our office welcomes emergency appointments; however, there may be a wait before you are seen. It is our policy that those patients with scheduled appointments will be given priority. In the event you have to cancel your scheduled appointment please do so within 24 hours of your scheduled appointment time so as to avoid possible dismissal as it will count as a broken appointment. _____ (Initial)

Appointment Confirmation Policy

Here at Aira Dental, we enforce a strict confirmation policy. Office personnel will always contact the patient **1 week prior** to each dental appointment in an attempt to confirm the appointment. We allow **3 business days** for a confirmation call back. In the event that you attempt to reach our office after hours, please leave a message as your appointment can be confirmed this way as well. If you have failed to confirm during this **three day** window, we will assume that you cannot make your appointment and reserve the right to **remove your appointment** from the schedule. In the event you do show up for the appointment without confirmation, we will try our best to work you back into the schedule. Please remember that it is your responsibility to keep us informed of any changes to your contact information. If your phone number has changed or has been disconnected, it will still be considered "un-confirmed" and will be removed from the schedule.
_____ (Initial)

HIPAA Consent

I understand that as part of my health care, Aira Dental originates and maintains paper records describing my health history, examinations, test result, diagnosis, treatment and any plan(s) for future care or treatment.

I understand that this information serves as:

A means of communication among the health professional who contribute to my care.
A basis for planning my care and treatment.
A source of information for applying my diagnosis and surgical information to my bill.
A method by which my health plan can verify that services billed were actually provided, and
A tool for routine healthcare operations such as quality assessment.

I understand that I have the following rights and privileges:
The right to object the use of my health information for directory purposes, and the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.
I understand that if I put restrictions on how my health information is used, Aira Dental is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the actions the organization may have already takes. I also understand that by refusing to sign this consent or revoking this consent, Aira Dental may refuse to treat me.

I wish to apply the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operation. It may be necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I understand and accept the terms of this consent

X_____ Date ____/_____/_____

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

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ 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 ☐ Text Message to my Cell Phone

☐ Home Phone Confirmation

☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone

☐ Home Phone Confirmation

☐ Work Phone Confirmation ☐ **Any of the Above**

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