



PATIENT INFORMATION

Patient Name: _____ DOB: _____ Male / Female

Preferred name: _____

Email: _____ SS#: _____ - _____ - _____

Street Address: _____

City: _____ State: _____ Zip: _____

Primary Phone Number: _____

Secondary Phone Number: _____

Marital Status: Married / Single / Divorced / Widowed

Name of Spouse or Guardian: _____ DOB: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone Number: _____

INSURANCE INFORMATION

Insurance carrier: _____ Member ID: _____

Policy holder name: _____ Date of Birth: _____

Employer: _____ Phone Number: _____

AUTHORIZATION

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have also read and fully understand all the information on this form and have completed the above answers. I therefore, certify this information is true and correct to the best of my knowledge. If any changes occur with my health status or the above information, I will notify The Loop Endodontics. I authorize the release of any information relating to this claim. I hereby authorize payment directly to The Loop Endodontics or the group insurance benefits otherwise payable to me.

Print Name: _____

Date: _____

Signature: _____

MEDICAL HISTORY

Patient Name: _____

DOB: _____

General Physician: _____

Phone Number: _____

Fax Number: _____

WOMEN ONLY:

Pregnant: YES / NO If YES, how many weeks: _____

Nursing: YES / NO Taking oral contraceptive: YES / NO

Are you allergic to any of the following: (Please circle)

Aspirin / Penicillin / Codeine Darvon / Valium

Percodan / Local Anesthetics / Erythromycin / Nitrous Oxide / Other

Are you under medical treatment now: YES / NO

Circle any if you have or you have had any of the following:

AIDS / HIV Positive	Chest Pain	Heart Murmur	Lupus
Anemia	Cold Sores	Heart Pacemaker	Mitral Valve Prolapse
Angina	Fever Blister	Hepatitis A, B, C	Psychiatric Care
Arthritis / Gout	Congenital Heart Disorder	Herpes	Recent Weight Loss
Artificial Heart Valve	Convulsions	High Cholesterol	Rheumatic Fever
Artificial Joint	Diabetes	High/Low Blood Pressure	Sinus Trouble
Asthma	Drug Addiction	Hypoglycemia	Stroke
Blood Disease	Epilepsy / Seizures	Irregular Heartbeat	Thyroid Disease
Breathing Problem	Excessive Bleeding	Kidney Problem	Tuberculosis
Cancer	Hay Fever	Leukemia	Tumor
Chemotherapy	Heart Attack / Failure	Liver Disease	Venereal Disease

Have you ever had a serious illness not listed above: YES / NO

If YES, please explain: _____

PHARMACY ADDRESS: _____

Phone number: _____

To the best of my knowledge, the question on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform The Loop Endodontics of any changes in medical status.

Print Name: _____

Date: _____

Signature: _____

Relationship: _____

MEDICATION LIST**Patient Name:** _____**Date of Birth:** _____Are you currently taking any medications: **YES / NO****If YES, please add medication on the following form**

DATE	MEDICATION NAME	STRENGTH	FREQUENCY	PHYSICIAN	DATE DISCONTINUED

PATIENT FINANCIAL RESPONSIBILITY DISCLOSURE AND ACKNOWLEDGMENT

Thank you for choosing The Loop Endodontics as your dental provider. We are committed to your treatment being successful. Your signature on the line below forms a legally binding agreement between The Loop Endodontics and the undersigned patient (the "Patient") who is receiving dental care, or the responsible party for minor patients (those patients under 18 years of age). The Responsible Party is the individual who is financially responsible for payment of dental bills associated with the dental services provided by the Loop Endodontics, and is the individual indicated on the form below as the Responsible Party in the space provided. The patient, if over the age of 18 years of age is the Responsible Party. The following is a statement of our payment policy. This payment policy applies to all services provided by The Loop Endodontics regardless of the location.

All charges for services rendered are due and payable at the time of service.

For our Patients with no Dental Insurance Benefits:

If you do not have dental insurance, payment for all professional services is expected at the time of your visit.

For our Patients with Dental Insurance Benefits:

The providers of The Loop Endodontics participate in most major dental plans and will verify eligibility and coverage for all insurances. Our business office will submit a claim for any services rendered to a patient; however, it is the Responsible Party's responsibility to pay the entire amount of all services rendered. It is the Responsible Party's responsibility to provide all necessary information and complete any required forms before leaving the office. The Loop Endodontics will not pursue secondary insurance coverage. That is your responsibility as the patient. Please contact your insurance company with any questions about your insurance's coverage.

In addition, your insurance company may be based on fees considered "usual and customary" that differs from ours. We charge what is usual and customary for our practice. **You are responsible for payment in full regardless of your insurance company's arbitrary determination of "usual and customary" rates.**

Please remember that insurance is a contract between you and insurance company. Our office is not part of this contract. **You are responsible for the timely payment of your account.** We cannot waive co-payments, deductibles, co-insurance or non-covered service amounts defined as patient responsibility under terms of our contract with various health plans. Payment of co-payments and co-insurance are due at the time of the office visit.

Any remaining balance on your account after the insurance company has processed your claim and sent the Explanation of Benefits is due and owing within 30 days of receiving a statement from our office. Failure to pay all unpaid balances within 30 days of receiving a statement from our office will result in a billing fee of \$15 to cover the cost of a statement being sent to you.

Print Name: _____

Date: _____

Signature: _____

Relationship: _____

OFFICE POLICY**Missed Appointments:**

Failure to give a 24-hour notice of an appointment or not showing up for an appointment will result in a charge of \$49 on your account. This charge cannot be billed to the insurance company and will be your responsibility. Failure to pay a no-show fee will be treated according to our policy on unpaid balances, with the exception of collection notices. A 24-hour notice is required to change a scheduled appointment.

Confirming Your Reserved Appointment:

We value your time and have reserved the doctors time to see you. **To ensure that you keep this reserved appointment, you need to confirm through email, or phone.** We will start this process 1 week prior to your reserved appointment time and you have to simply reply to us that you can still make it. We will try and contact you a total of 4 times through email or phone. If we hear back from you during any of those attempts, we will not contact you anymore until the day of your appointment as a reminder. If you plan to change your reserved appointment time, **we require a notice of 2 business days. If you do not confirm your appointment within 2 business days prior to your appointment, you will lose your reserved appointment time and would have to reschedule.**

Methods of Payment:

Cash, Visa, Mastercard, American Express, Apple Pay and Care Credit. Charge backs are considered theft of retail services via the act of conversion. This offense is handled by the local police department and settled through prosecution by the state attorney's office. All fees associated with prosecution will be accepted by the undersigned.

Past Due Accounts:

In the event that The Loop Endodontics should initiate collection proceedings or other legal action to collect an overdue account, the Responsible party acknowledges and understands that The Loop Endodontics has the right to and shall disclose to its outside collections agency all relevant personal and account information necessary to collect payment for services rendered, including any applicable Service Charges and applicable costs of collections. The Responsible Party understands and acknowledges responsibility for all costs of collections, including without limitations Attorneys' fees and costs, court costs, and the interest shall accrue on all unpaid balances at the rate of 1 ½ % per month (18% per annum).

Please be advised that if a balance remains unpaid, the patient may be discharged from The Loop Endodontics. We hold the right to refuse to see a patient who has an unpaid balance.

By Signing below, you agree to accept full responsibility as a patient who is receiving dental services, or as the Responsible Party, as applicable. Your signature below verifies that you have read the above disclosures, understood your responsibilities, and agree to the terms set forth herein.

Print Name: _____
Signature: _____

Date: _____
Relationship: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICE

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). (Copy is given as requested) I understand this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Print Name: _____

Date: _____

Signature: _____

Relationship: _____

Persons authorized to obtain information about the patient's account or treatment:

Name: _____

Relationship: _____

Name: _____

Relationship: _____

*****For Office Use Only*****

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reasons.

- ☐ The patient refused to sign
- ☐ Communication Barrier
- ☐ Emergency Situation

Witness Name: _____

Witness Signature: _____