

# Welcome

We are glad you chose us for your family dental care. It is our main goal to meet all of your general and preventive dental healthcare needs. In order for us to do this, please fill out this form completely and return it to the receptionist. The better we communicate, the better we can care for you. All information is, of course, confidential. If you need any assistance, please ask us - We will be happy to help.

## PATIENT INFORMATION

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Home #: \_\_\_\_\_

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc Sec#: \_\_\_\_\_ Cell #: \_\_\_\_\_

Sex: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Address: \_\_\_\_\_

(Include City, State, and Zip Code)

Employer: \_\_\_\_\_ Work #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact #: \_\_\_\_\_ Insurance Name: \_\_\_\_\_

## Dental History

Date of last dental visit: \_\_\_\_\_ Previous Dentist's Name: \_\_\_\_\_

How often do you brush?: \_\_\_\_\_ Floss?: \_\_\_\_\_

## Have you ever:

Yes Or No:

- Had a problem with bleeding?
- Had a problem with swelling?
- Had a problem with drug reaction?
- Had a problem with dry socket?
- Been instructed regarding proper home care of your teeth or gums?
- Do you frequently get cold sores, blisters, or other oral lesions?
- Do you smoke or chew tobacco?
- Had a serious injury to your mouth?
- Had a serious injury to your jaw?
- Had a serious injury to your head?
- Had a serious injury to your face?
- Had full or partial dentures? **If yes, how long?** \_\_\_\_\_
- How long have you worn your current prosthesis?
- Have you ever had a reline?
- Are you presently having any problems with your dentures?
- Felt nervous about having dental treatment?

## MEDICAL HISTORY

Physician's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Yes or No:

- Have you ever been told you need Antibiotic Prophylaxis (pre-medication) prior to any dental treatment?
- Do you consider yourself to be in good health?
- Are you currently under a physician's care?
- Do you or have you taken Fosamax?
- Are you currently taking any medications? If yes, please list below:
- \_\_\_\_\_
- \_\_\_\_\_

**Are you aware of having an allergic or adverse reaction to any of the following:**

- Penicillin     Tetracycline     Sulfa     Erythromycin     Latex
- Aspirin     Dental Anesthetics     Codeine     Metals     Other

**Females: Are you:**     pregnant?     nursing?     Taking birth control pills?

**Indicate which of the following you have had, or have at present:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Heart(surgery, disease, attack)   | <input type="checkbox"/> Ulcers                   | <input type="checkbox"/> Back/Neck Problems             |
| <input type="checkbox"/> Chest Pain                        | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Hepatitis                      |
| <input type="checkbox"/> Congenital Heart Disease          | <input type="checkbox"/> Thyroid Problems         | <input type="checkbox"/> Venereal Disease               |
| <input type="checkbox"/> Heart Murmur                      | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> AIDS/HIV Positive              |
| <input type="checkbox"/> Low Blood Pressure                | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Cold Sores/Fever Blisters      |
| <input type="checkbox"/> High Blood Pressure               | <input type="checkbox"/> C.O.P.D.                 | <input type="checkbox"/> Blood Transfusion              |
| <input type="checkbox"/> Mitral Valve Prolapse             | <input type="checkbox"/> Emphysema                | <input type="checkbox"/> Hemophilia                     |
| <input type="checkbox"/> Artificial Heart Valve            | <input type="checkbox"/> Chronic Cough            | <input type="checkbox"/> Sickle Cell Disease/Trait      |
| <input type="checkbox"/> Heart Pacemaker                   | <input type="checkbox"/> Tuberculosis             | <input type="checkbox"/> Bruise Easily                  |
| <input type="checkbox"/> Rheumatic Fever                   | <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Liver Disease                  |
| <input type="checkbox"/> Arthritis/Rheumatism              | <input type="checkbox"/> Yellow Jaundice          | <input type="checkbox"/> Cortisone Medication           |
| <input type="checkbox"/> Allergies or Hives                | <input type="checkbox"/> Neurological Disorders   | <input type="checkbox"/> Swollen Ankles                 |
| <input type="checkbox"/> Sinus Trouble                     | <input type="checkbox"/> Epilepsy/Seizures        | <input type="checkbox"/> Leukemia                       |
| <input type="checkbox"/> Radiation Therapy                 | <input type="checkbox"/> Fainting or Dizzy Spells | <input type="checkbox"/> Stroke                         |
| <input type="checkbox"/> Diet (Restricted/Special)         | <input type="checkbox"/> Chemotherapy             | <input type="checkbox"/> Nervous/Anxious                |
| <input type="checkbox"/> Artificial Joints(hip, knee, etc) | <input type="checkbox"/> Tumors/Cancer            | <input type="checkbox"/> Psychiatric/Psychological Care |
| <input type="checkbox"/> Kidney Disease                    | <input type="checkbox"/> Drug/Alcohol Abuse       | <input type="checkbox"/> Other? _____                   |

Patient or Responsible Party Signature: \_\_\_\_\_

**Responsible Party (Parent or if different than Patient):**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

SSN#: \_\_\_\_\_ Birth date: \_\_\_\_\_ Driver's License#: \_\_\_\_\_



## Financial Policy

**Patients with Dental Insurance:** As a courtesy to you, our office will gladly submit services to your insurance. We are able to bill to traditional, indemnity insurance plans. We do not accept DMO or DPO plans (Dental Maintenance or Dental Provider Organizations). Under these plans, there is NO COVERAGE when treatment is rendered by a non-participating dentist. Please review your plan type carefully. We are an in-network provider with many policies; Delta Dental Premiere, Connection Dental, Guardian, Humana, United Concordia, MS Medicaid, MSCan, and MS Chips. For specific information about in or out-of-network benefit amounts please contact your insurance company.

**Authorization to Release Info and Assignment of Benefits:** I certify that I, \_\_\_\_\_, (or my dependent) have (has) dental insurance coverage and assign directly to Collier Dental all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor and/or the staff to release all necessary personal information to my insurance company in order to secure the payment of benefits.

**Payments:** We accept cash, check, all major credit cards, Wells Fargo, Citi, and Care Credit. Payment of your "estimated" portion is due at the time services are rendered, such as your annual deductible and/or percentage of the treatment not covered by insurance. As a courtesy, we will gladly contact your insurance in order to provide an "estimate" of your patient portion. However, despite this, we cannot **guarantee** the payment of insurance benefits nor can we provide 100% accuracy of this estimated amount since many factors are involved that determine the actual payment of benefits once submitted and processed by your insurance. Should an outstanding balance result after your insurance company processes your claim, you will then be sent a statement. Payment in full is due by the due date printed on the statement. Our office policy does not allow partial payments. If a credit balance should result after insurance processes your claim, a refund will be promptly issued to you.

**Unpaid Insurance Claims:** All dental services rendered, whether or not covered by insurance, are ultimately the financial responsibility of the account holder. We will give your insurance company 60 days to remit payment. If there is still no payment after this time, in order to keep your account current, you will be financially responsible for 100% of the outstanding insurance claim. A statement will be sent to you, and payment in full will be due on the date printed on the statement. It is the responsibility of the account holder to follow up with their own insurance company regarding the non-payment of a claim. Should our office eventually receive a payment from your insurance after it has been paid by you, a prompt refund will be issued.

**Past Due Accounts:** If payment is not received by the due date printed on the statement, then your account is considered "past-due". We reserve the right to impose a service charge of 2% per month (18% per annum) on the unpaid balance on all accounts exceeding 30 days, unless previous financial arrangements have been made. If the balance is still unpaid after 90 days, the account will be turned over for further collection action and a 35% collection fee will be added to your total balance. If an account is turned over to our collection agency and/or our attorney for collection, the account holder will be responsible for ALL attorney and/or collection fees that this office incurs while attempting to collect on the unpaid balance. These collection fees will be added to the outstanding portion of the account, and will also become the financial responsibility of the account holder.

**Patients without Dental Insurance:** Payment in full is expected at the time services are rendered. We accept cash, checks, all major credit cards, Well Fargo, Citi, and Care Credit.

**Broken/Missed Appointments:** We request at least 48 hours' notice before cancelling or rescheduling an appointment. That way, we have time to fill the opening in our schedule. We reserve the right to charge your account \$25.00 if we are not notified at least 24 hours prior to your appointment. Thank you for assisting us in keeping our schedule full.

Collier Dental reserves the right to update and make changes to the above-stated financial policies at any time without prior notification.

*By signing below, I verify that I completely understand, agree, and accept the policies outlined above. I further acknowledge that I am responsible for all dental services rendered for me and my dependents (if applicable).*

Patient Name (print): \_\_\_\_\_ Date: \_\_\_\_\_

Responsible Party Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Acceptance Of Disclosure Statement:**

I have read a copy of the Notice of Privacy Practices for Protected Health Information and have had an opportunity to ask questions concerning that Notice given to me by Dr. John Collier, Dr. Larissa Hammer, or his staff.

Accepted

Declined

\_\_\_\_\_

(Patient or Patient’s Representative)

\_\_\_\_\_

(Date)

\_\_\_\_\_

(Witness)

\_\_\_\_\_

(Date)

I request the following restrictions to the use or disclosure of my health and/or dental information.

\_\_\_\_\_

**Insurance Information:**

Primary Insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Birth date: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

You are responsible for knowing the benefits of your insurance policy. Any estimates given are subject to be denied by your insurance company. By signing below, I am aware that I am responsible for payment of any denied services.

\_\_\_\_\_

(Signature)

\_\_\_\_\_

(Date)

**Authorization and Release:**

I certify that the information I have given is complete and accurate to the best of my knowledge. I will not hold my dentist, or any other member of their staff responsible for any errors or omissions that I may have made in the completion of this form. I will notify the dentist of any change in my health or medication. I hereby authorize doctor or designated staff to take radiographs, study models, photographs and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of myself or child’s dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper case. Due to the increased cost of mailing statements and trying to keep fees as low as possible, we find it necessary to expect our patients to pay for the services they receive at that time, unless prior arrangements have been made. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. In the event that payment for dental services is not made within sixty (60) days of treatment, then interest at the legal prevailing rate, plus a service charge may be added to the past due balance. If collections and/or legal services are required to receive payment of the past due balance, I will be responsible for all collection costs and reasonable attorney fees incurred in connections with the collection efforts. A minimal charge may be assessed for failed or cancelled appointments without at least 24 hour prior notification.

**Information to better serve you!**

What is your email?: \_\_\_\_\_

Would you like to be emailed or text messaged to confirm future appointments?: \_\_\_\_\_

Who can we thank for referring you here?: \_\_\_\_\_

What did you like about your former dentist?: \_\_\_\_\_

If the patient is a student, what is the name of their school?: \_\_\_\_\_