Privacy Policy and Information Practices Patient Rights Statement
Use and Disclosure of Health Information Consent Form

Consent: By signing this form, you do consent to our use and disclosure of your personal health information to carry out treatment, payment activities and other healthcare operations required by this office. You acknowledge you are aware of our need to share your protected personal health information and have received your patient rights notification explaining in detail our office Privacy Policy and Information sharing Policy.

Right to revoke: You have the right to revoke this Consent at any time by giving us written notice. We will honor the request as of the day we receive your written notice. Please understand it will not affect any action taken before we received your revocation and we may decline to treat you or to continue treating you if you revoke this Consent.

Changes to Privacy Practices: We reserve the right to change our privacy practices described in our Patients Rights Privacy Policy and Information Practices. If we change our practices we will issue a revised Patients Rights Privacy Policy and Information Practice statement.

Patient Responsibility: We request timely notification of any changes to your personal information we maintain for you, such as but not limited to, health history information, address, telephone number, active insurance policy, and change in employer.

I, _____, *have received a copy of the above*
Please Print Name
named office's Privacy Policy and Information Practices. I have read and understand the above information. I understand that by signing this form I am giving my consent to use and disclose my protected health information to carry out treatment, payment activities and health care operations.

⇨ _____ _____ _____
Signature Date Witnessed

Consenting Patient Information:

Name: _____Date of Birth_____

Address: _____
Street City State Zip

Telephone: _____
Home Work Cell

Minor children also covered by this consent:

Name:_____Date of Birth_____
Name:_____Date of Birth_____
Name:_____Date of Birth_____
Name:_____Date of Birth_____

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Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Social Security #: _____ Birth Date: _____ *Age:* ___ Gender: _____ Marital Status: _____

Phone (Home): _____ (Work): _____ (Cell): _____ Email: _____

Address: _____
Street Apartment # City State Zip Code

Employer: _____ Occupation: _____ Years at this job: _____ Drivers Lic#: _____

In case of Emergency Contact: _____
Name Relationship Home Phone Work/Cell Phone

Whom may we thank for referring you to our practice? _____

Medical History

Are you currently under a physicians care? □ Yes □ No If so, for what reason? _____

Physicians Information _____(___)_____
Dr's Name Address City State Zip Phone

Please mark any of the following you may have had, or have at present:

□ Rheumatic Fever
□ Heart Murmur
□ Congenital Heart Disease
□ Artificial Heart Valve
□ Pacemaker
□ High/Low Blood Pressure
□ Heart Attack or Heart Disease
□ Blood thinning treatment
□ HIV or AIDS
□ Hepatitis or Liver Disease
□ Venereal Disease
□ Inner Ear Disorders or Surgery
□ Artificial Joint
□ Surgical Prosthesis
□ Ulcers/Stomach Problems
□ Cancer or Related Treatment
□ Kidney Trouble
□ Diabetes
□ Glaucoma
□ Scarlet Fever
□ Thyroid Disease
□ Tuberculosis
□ Arthritis/Rheumatism
□ Stroke
□ Epilepsy or seizures
□ Fainting or dizzy spells
□ Psychiatric treatment
□ Osteoporosis
□ Bruise Easily
□ Asthma
□ Hay Fever
□ Emphysema
□ Allergies or Hives
□ Sinus trouble
□ Cold sores or herpes
□ Other: _____

For Women Only-
Are you pregnant? □ Yes □ No
Due Date: _____
Are you nursing? □ Yes □ No
Do you take birth control? □ Yes □ No

Do you or have you used:
□ Tobacco
□ Alcohol
□ Illegal IV Drugs
□ Other: _____

Have you ever been requested to take antibiotics or other medications before a dental appt? □ Yes □ No
Is there anything else we should know about your health that is not covered on this form? □ Yes □ No

Medications

List all medications and dietary supplements you have taken in the last 3 months. Include dosage and reason for taking the medication _____

Allergies

Mark all medications or health care related substances to which you have experienced an allergic or adverse reaction:

□ Penicillin □ Sulfa drugs □ Others _____
□ Codeine □ Epinephrine _____
□ Latex □ Local Anesthetics □ None

I certify that the above medical information is complete and accurate.

_____ _____
Signature of patient, parent or guardian Date Dentist Signature Date

Dental History

Reason for seeking dental care at this time _____ Date of last dental visit _____ Reason? _____
Date of last X-rays _____ Former Dentist _____ City/State _____ Phone # _____

How often do you: Brush 1 / 2 / 3 times per day / week Floss 0 / 1 / 2 / 3 times per day / week / month

How do you feel about dental treatment? □ **Relaxed** □ **A little uneasy** □ **Tense** □ **Anxious** □ **Very Anxious**

Do you or have you ever had any of the following?

□ Periodontal / Gum Disease
□ Perio Cleanings / Treatment
□ Sensitive or bleeding gums
□ Grinding or clenching
□ Swelling or lumps in mouth
□ Loose teeth
□ Cold sores
□ Bad breath
□ Swollen glands
□ Aching or sensitive teeth
□ Areas of food traps
□ Difficulty opening wide
□ Clicking or popping in jaw
□ Jaw pain or tiredness
□ Orthodontic treatment
□ Unfavorable dental experience
□ Growths or lesion in your mouth
□ Broken or missing teeth / fillings
□ Dry mouth
□ Other _____

If you could change your smile, what would you change?

□ Remove unsightly fillings
□ Straighten teeth
□ Change shape of teeth
□ Replace missing teeth
□ Close gaps between teeth
□ Make teeth same color
□ Whitening
□ Other _____

Would you like to speak with the doctor privately about any matter? □ Yes □ No

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the patient's guardian if patient is a minor ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____ Employer: _____

Phone (Home): _____ (Work): _____Ext: _____ (Cell): _____

Address: _____

Street Apartment # City State Zip Code

Insurance Information

Primary Dental Insurance:

Insurance Plan Name and Address: _____ Group #: _____

_____

Insurance Company Phone Number: _____Electronic Payor ID#_____

Name of Subscriber: _____Is subscriber a patient? ☐ Yes ☐ No

Last First MI

Subscriber's Birth Date: _____ Social Security #: _____ ID #: _____

Subscriber's Address: _____

Street City State Zip Code

Subscriber's Employer Name: _____Employer Phone: _____

Employer Address: _____

Street City State Zip Code

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary Dental Insurance Information:

Insurance Plan Name and Address:_____Group #: ___

_____

Insurance Company Phone Number:_____Electronic Payor ID#_____

Name of Subscriber: _____Is subscriber a patient? ☐ Yes ☐ No

Last First MI

Subscriber's Birth Date: _____ Social Security #:_____ ID #: _____

Subscriber's Address: _____

Street City State Zip Code

Subscriber's Employer Name: _____Employer Phone: _____

Address: dfddfdd _____

Street City State Zip Code

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Consent

I, the undersigned, hereby authorize the Doctor to take radiographs, study models, photographs, or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the Doctor employ any such assistance as he/she deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records.

I certify that the above insurance information, if applicable, is correct and in force. I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitations and exclusions. I understand that filing of insurance claims is my responsibility and may be provided as a service to me by Pacific Family Dental, and that any agreement for dental coverage is between my insurance company and myself. I understand that an estimated portion is due at the time of service and is estimated according to expected coverage, which may not be disclosed nor guaranteed by my insurance company. I understand my portion may be more if my insurance company does not pay the anticipated amount. I also understand that services are rendered independent of insurance reimbursement.

I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins. I agree that credit bureau reports may be obtained, where appropriate. I will notify Pacific Family Dental if there is a change in the family relationship on the account (divorce, separation, adoption).

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent, guardian or responsible party

Insurance & Payment Explanation

Pacific Family Dental welcomes you as our new patient. We would like to take this opportunity to explain the benefits of dental insurance as we know it. Insurance can be confusing with terms such as co-payments, deductibles and percentages.

Pacific Family Dental is a fee for service dental office. We ask, that at the time of service, you pay your "estimated" portion based on your dental insurance's verification of benefits.

As a courtesy, Pacific Family Dental contacts each and every patient's insurance company to get a basic breakdown of insurance benefits to best help you in planning for your dental expenses. Please understand that this is not a guarantee of payment by your insurance company, only an estimation of payment. Be aware that if we are unable to verify insurance coverage for you, we must collect payment in full for any services provided that day.

Most dental insurance companies cover a percentage of your total cost for dental services. However, most insurance companies will only pay the percentage of their own determined cost of a procedure, regardless of the billed amount or the "usual and customary" cost for a procedure in this area. This leaves a difference between your "estimated" responsibility (due at the time of service) and your actual responsibility. Unfortunately we are limited by what your insurance company is able to tell us. This difference in cost is then billed to you after all outstanding claims have been paid. This balance is your responsibility to pay and is due upon receipt of the statement.

Example

Let's say that a dental procedure you had today has a fee of $92.00
Your insurance plan benefit states that they cover 80% of this service. We estimate your portion to be $18.40 due at the time of service.
Your insurance company sends payment of $57.60 (This is 80% of your insurance company's determined maximum for this procedure or $72.00).
This leaves you with a balance on your account of $16.00 which is then billed to you.

If you have any questions about the above explanation, please ask us and we will do our best to clarify.

We appreciate your understanding of the limitations we are provided by your insurance company. We aim to give you the best quality of care and service that you deserve. We would be happy to accommodate your request for a preauthorization for treatment from your insurance company if you would prefer. You are also welcome to ask your insurance company for a copy of their fee maximums in order to better estimate your payment responsibility.

Please note that past-due accounts will be assessed a late charge of 1.5% per month on any outstanding balances. There will be a $25 charge for any returned checks.

We reserve the right to charge **$75 for missed appointments** if we do not receive **48 hour notice** prior to cancellation.

Thank you for being a Pacific Family Dental patient!