Uptown Dental Group

PLEASE COMPLETE ALL INFORMATION THAT APPLIES TO YOU - THANK YOU

PATIENT LAST NAME: _____ **FIRST:** _____ **INITIAL:** _____

How do you wish to be addressed? _____ DOB _____

(❑ Single ❑ Married ❑ Divorced) (❑ Male ❑ Female) Full time Student? ❑ Yes ❑ No School _____

Address _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Employer _____ Occupation _____

Soc. Sec. No. _____ Dental Insurance Co. _____ Group _____

Is patient covered by another dental insurance? ❑ Yes ❑ No Insurance Co. _____

How did you hear about our practice? Whom may we thank for your referral? _____

HUSBAND, FATHER OR RESPONSIBLE PARTY (IF OTHER THAN PARENT)

Last Name _____ First _____ Initial _____

Address _____ DOB _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Employer _____ Occupation _____

Soc. Sec. No. _____ Dental Insurance Co. _____ Group _____

WIFE, MOTHER OR RESPONSIBLE PARTY (IF OTHER THAN PARENT)

Last Name _____ First _____ Initial _____

Address _____ DOB _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Employer _____ Occupation _____

Soc. Sec. No. _____ Dental Insurance Co. _____ Group _____

NEAREST RELATIVE

Last Name _____ First _____ Initial _____

Address _____

City _____ State _____ Zip _____ E-Mail _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

AUTHORIZATION

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any 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 authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits **may pay less** than the actual bill for services. I understand **I am financially responsible** for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer.

I attest to the accuracy of the information on this page.

Signature _____ Date _____

INSURANCE VERIFICATION

PHOTOCOPY AND PLACE
FRONT SIDE OF DENTAL CARD HERE

PHOTOCOPY & PLACE
BACK SIDE OF DENTAL CARD HERE

BENEFIT BREAKDOWN

_____ % Diagnostic – Freq.
FMX Freq. ❑ Class I ❑ Class II
BWX Freq. ❑ Class I ❑ Class II
_____ % Preventative Freq.
_____ % Restorative
_____ % Endodontics
_____ % Periodontics
_____ % Pros. Removal
_____ % Implants
_____ % Pros. Fixed
_____ % Oral Surgery
_____ % Orthodontics - Age _____
_____ % Adjunctive Gen Svc/Nitrous
_____ % Single Crowns – ❑ Basic ❑ Major
_____ % Sealants Age: _____ Freq: _____
_____ % Fluoride Age: _____ Freq: _____
_____ **Benefit Maximum (*required)**
_____ **Ortho Maximum (*required)**

BENEFIT BREAKDOWN

Plan Type: ❑ Capitation Plan ❑ PPO ❑ Traditional ❑ Premier
Fee Schedule: _____ ***required***
Deductible Applies To: ❑ Class I ❑ Class II ❑ Class III ❑ Class IV
Individual Deductible: _____
Family Deductible: _____
Prosthetic Replacement: ❑ Yes ❑ No
If Yes, How Long?: _____
Waiting Period: ❑ Yes ❑ No
If Yes, How Long?: _____

NOTES

Uptown Dental Group

PLEASE COMPLETE ALL INFORMATION – THANK YOU

PATIENT LAST NAME: _____ **PATIENT FIRST NAME:** _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental visit _____

Former dentist _____ Date of last dental x-rays _____

Please check if you have/had:	Yes	No		Yes	No
Bad breath	❑	❑	Head, neck, jaw pain, or aches	❑	❑
Blisters on lips or mouth	❑	❑	Lip or cheek biting	❑	❑
Burning sensation on tongue	❑	❑	Loose teeth or broken fillings	❑	❑
Chew on one side of mouth	❑	❑	Mouth breathing	❑	❑
Cigarette, pipe, or cigar smoking	❑	❑	Orthodontic treatment	❑	❑
Smokeless tobacco	❑	❑	Nitrous Oxide	❑	❑
Dry mouth	❑	❑	Periodontal treatment	❑	❑
Food collection between teeth	❑	❑	Sensitivity to pressure or irritants	❑	❑
Clench or grind teeth	❑	❑	(cold, heat, sweets)		
Growths or sore spots in your mouth	❑	❑	How often do you floss? _____		
Gums swollen, tender or bleeding	❑	❑	How often do you brush? _____		

Have you ever had an allergic reaction to Novocaine, local, or general anesthetics? ❑Yes ❑No

If Yes, please explain _____

_____

_____

Have you ever had trouble from previous dental care?

❑Yes ❑No If Yes, please explain _____

_____

_____

MEDICAL HISTORY

Physician's name _____ Date of last visit _____

Physician's address _____ _____Blood Pressure_____

Have you had any serious illnesses or operations Yes ❑ No ❑ If yes, please describe _____

Have you ever had a blood transfusion Yes ❑ No ❑ If yes, give approximate dates _____

(Women) Are you pregnant? Yes❑ No❑ Due date _____ Nursing? Yes ❑ No❑ Taking birth control pills? Yes ❑ No ❑

Please check if you have/had:	Yes	No		Yes	No		Yes	No
Allergies, hay fever, sinusitis	❑	❑	Headaches	❑	❑	Slow healing wounds	❑	❑
Anemia	❑	❑	Heart murmur	❑	❑	Stroke	❑	❑
Arthritis, Rheumatism	❑	❑	Heart problems	❑	❑	Swelling of feet or ankles	❑	❑
Artificial heart valves	❑	❑	Hepatitis type _____	❑	❑	Thyroid problems	❑	❑
Artificial joints	❑	❑	Herpes	❑	❑	Tonsilitis	❑	❑
Asthma	❑	❑	High blood pressure	❑	❑	Tuberculosis	❑	❑
Required Hospitalization	❑	❑	Any immune deficiency	❑	❑	Tumor or growth on head/neck	❑	❑
Have you used steroids	❑	❑	Jaundice	❑	❑	Ulcer	❑	❑
Date of last episode _____	❑	❑	Kidney disease	❑	❑	Venereal disease	❑	❑
Bleeding abnormally with operations or surgery	❑	❑	Low blood pressure	❑	❑	Weight loss, unexplained	❑	❑
Blood disease, clotting disorders	❑	❑	Mitral valve prolapse	❑	❑	Do you wear contact lenses?	❑	❑
Cancer	❑	❑	Osteoporosis	❑	❑	Do you consume alcoholic beverages?	❑	❑
Chemical dependency	❑	❑	Osteopenia	❑	❑	Are you currently under the care of a Physician?	❑	❑
Chemotherapy	❑	❑	Pacemaker	❑	❑	Are you allergic/sensitive to Latex?	❑	❑
Circulatory problems	❑	❑	Radiation treatments	❑	❑	Allergic to Penicillin, Aspirin, or other drugs?	❑	❑
Cortisone treatments	❑	❑	Respiratory disease	❑	❑	*If Yes, please specify* _____		
Cough, persistent or bloody	❑	❑	Rheumatic fever	❑	❑	_____		
Diabetes	❑	❑	Scarlet fever	❑	❑	_____		
Emphysema	❑	❑	Shortness of breath	❑	❑	List any medications that you are taking:		
Epilepsy	❑	❑	Sinus trouble	❑	❑	_____		
Fainting	❑	❑	Sickle cell anemia	❑	❑	_____		
Glaucoma	❑	❑	Skin rash	❑	❑	_____		

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature _____ Date _____

Reviewed by: _____ Date _____

DENTAL & MEDICAL HEALTH HISTORY

MEDICAL HEALTH HISTORY – UPDATE AND EXCEPTIONS

I have read my medical history and confirm that it adequately states past and present conditions

DATE	EXCEPTIONS	NONE	PATIENT INITIALS	REVIEWED BY

Uptown Dental Group

SECTION A: PATIENT GIVING CONSENT

Patient Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

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 the 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:

Compliance Officer: ISMILEL DENTAL CARE
Telephone: (908)810-1234
A

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.

SECTION C: SIGNATURE

I, _____ have had full opportunity to read and consider the contents of this Consent form and the 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 heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

SECTION D: 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
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (please specify) _____

Signature: _____ Date: _____

You are entitled to a copy of this consent after you sign it.

PRIVACY PRACTICES RECEIPT / CONSENT FORM

SECTION E: REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

If this Revocation of Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

SECTION F: PATIENT/RELATIVE HIPAA CONSENT

I, _____ , understand that by signing this Consent form, I am giving my consent to Great Expressions Dental Centers to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations with the following family member:

Name: _____

Relationship: _____

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 Compliance Officer listed on Section B.

_____ _____

Patient's Signature (Legal Guardian, if Patient is a minor) Date:

SECTION G: RESTRICTION OF PROTECTED HEALTH INFORMATION (PHI)

I request Great Expressions Dental Centers restrict the disclosure of my PHI to those specified below:

Name: _____

Name: _____

Signature: _____ Date: _____

If this Restriction of PHI is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Uptown Dental Group

PATIENT NAME: _____ **DATE:** _____

Great Expressions Dental Centers and affiliated companies, collectively known as "ISMILE", are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- **ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING THE DENTAL PROFESSIONAL.**
- **FULL PAYMENT IS DUE AT TIME OF SERVICE.**
- **WE ACCEPT CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER AND CARE CREDIT.**
- **GEDC PROVIDES INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT PORTION OF PARTICULAR DENTAL SERVICE(S) IS ESTIMATED AND DUE AT THE TIME OF SERVICE.**

ADULT PATIENTS

Adult patients are responsible for full payment at time of service.

MINORS ACCOMPANIED BY AN ADULT

The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

UNACCOMPANIED MINORS

The parents or guardians are responsible for full payment at time of service. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, or to Visa, Master Card or Discover. We do not accept American Express payments for visits by unaccompanied minors.

INSURANCE

ISMILE provides insurance company billing as a *courtesy* to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by ISMILE staff regarding his/her remaining benefit in any such benefit period.

The claims we submit to insurance companies indicate that you have assigned those benefits to ISMILE. However, if you are paid by the insurance company instead of ISMILE, you then become responsible for the total account balance and payment would be expected immediately.

If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available.

You as a patient are always responsible for any charges that are not covered by your insurance.

MEDICARE/ MEDICAID/ CHAMPUS/ WORKER'S COMPENSATION

If you are covered by Medicare, Medicaid, Champus, Worker's Compensation or any other government sponsored program, please discuss your payment situation with our office staff prior to arriving at the ISMILE office on the date of service.

DELINQUENT PAYMENTS

It is our policy to charge finance fees at 1.5% for outstanding patient balances after the balance has been outstanding 30 days. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of $25.00.

MISSED APPOINTMENTS

Unless cancelled at least 48 hours in advance, our policy is to charge for missed appointments at the rate of $35.00 per each 30 minutes of missed appointment time. Please help us service you better by keeping scheduled appointments.

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature _____ **Date** _____