Integrity DENTAL CLINIC

Patient Information

Last Name: _____First Name: _____MI:___ Preferred Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Child ☐ Widowed ☐ Separated

Sex: ___Female ___Male DOB: __/__/____ Soc. Sec. #: _____

Phone #s: Home (___) _____ Cell (___)_____ Work (___)_____ Best time to call:_____

Employer: _____ Occupation:_____

Employer's Address: _____

City: _____ State:_____ Zip Code:_____

Emergency contact: _____ Phone: (___)_____

Relation to Patient: _____

Primary Insurance

Person Responsible for Account: _____

Relation to Patient: _____ Birthday: _____ Soc. Sec. #: _____

Address (if different from patient): _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Employer: _____Occupation: _____

Employer's Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Insurance Company: _____

Group Plan: _____ Group #: _____ Subscriber #: _____

Names of other dependents covered by this plan: _____

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Secondary Insurance

Person Responsible for Account: _____

Relation to Patient: _____ Birthday: _____ Soc. Sec. #: _____

Address (if different from patient): _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Employer: _____Occupation: _____

Employer's Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Insurance Company: _____

Group Plan: _____ Group #: _____ Subscriber #: _____

Names of other dependents covered by this plan: _____

Authorization

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ **Date:** _____

Signature of patient, parent or guardian

PAYMENT IS DUE IN FULL AT TIME OF SERVICE

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Health History

Have you ever had any of the following? Please check those that apply:

- ☐ Allergies - _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer - _____
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis - _____
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Sulfa Allergy
- ☐ Other: _____

List All Medications and Reasons for taking them:

1._____ **5.**_____

2._____ **6.**_____

3._____ **7.**_____

4._____ **8.**_____

- **Have you ever had any complications following dental treatment? ☐ Yes ☐ No**
  - **If yes, please explain:** _____
- **Have you been admitted to a hospital or needed emergency care during the past two years?**
  - **If yes, please explain:** _____
- **Are you now under the care of a physician? ☐ Yes ☐ No**
  - **If yes, please explain:** _____

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- **Name of Physician: _____ Phone: _____**
- **Do you have any health problems that need further clarification? ☐ Yes ☐ No**
  - **If yes, please explain: _____**

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____

Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice?

- ☐ **Another patient, friend**
  _____
- ☐ **Another patient, relative**
  _____
- ☐ **Dental Office**
- ☐ **Facebook**
- ☐ **Co-worker _____**
- ☐ **www.integritydentalclinic.com**
- ☐ **Internet**
- ☐ **Other: _____**

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Patient's Name:_____Date:_____

Please list below person's who are authorized to discuss any kind of information regarding your family's account. If anyone calls or comes in the office and their name is not on this list we will NOT be releasing ANY information. Thank You!

Person's Name:	Relationship to Patient:
1._____	1._____
2._____	2._____
3._____	3._____
4._____	4._____
5._____	5._____

My signature below authorizes the above persons to discuss anything regarding my account.

_____**Date:**_____

Signature of patient, parent or guardian

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Patient's Name:_____Date:_____

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

_____**Date:**_____

Signature of patient, parent or guardian

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ASSIGNMENT OF BENEFITS AGREEMENT

Our office will accept an assignment of benefits from your insurance company with the provisions listed below. It is important to understand, though, that the agreement regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims:

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. **Completing insurance forms is a courtesy we extend to you in an effort to save you time and to facilitate payment to our office from your insurance company.** By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.

- We require you sign this agreement and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.

- We require you pay the estimated co-payment, which is the amount not covered by your insurance company, at the time we provide service to you. **The co-payment is only an estimate of charges and may be found to be insufficient after review by your insurance company.**

- Insurance payments ordinarily are received within 30-60 days from the time of billing. **If your insurance company has not made payment to our office within 60 days, we will ask you to pay the entire balance at that time.** You will be responsible for seeking reimbursement from your insurance company at that time.

- Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.

- Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

- Returned checks are subject to a $40.00 admin fee and all balances older than 60 days will be subject to collection action and fees.

I HAVE READ AND ACCEPTED THE TERMS AND CONDITIONS OF THIS ASSIGNMENT OF BENEFIT'S AGREEMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE DOCTOR.

_____ **Date:** _____

Signature of patient, parent or guardian