Date:_____

Sittason Family Dentistry
819 Highway 31 N, Suite A – Hartselle, Alabama 35640

PATIENT INFORMATION

Patient Name: _____ DOB: _____/_____/_____

SSN: _____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child

E-mail: _____ Cell #: (_____)_____-_____ Home #(_____)_____-_____

Address: _____

City: _____ State: _____ Zip: _____

Date of Last Dental Visit:_____ Reason for today's visit:_____

Has anyone ever informed you, you have Periodontal Disease or you need a "deep cleaning"?

☐ YES ☐ NO

How did you hear about our office? Please circle one.

PPO Google Facebook

Patient: _____ Other: _____

HIPAA

I understand that according to HIPAA law that this office is unable to discuss my treatment, account balance or any other matters pertaining to me unless I indicate that they may do so.

I agree that the following people can be informed of any association that I may have with this office including but not limited to treatment, diagnosis, financial arrangement, account balances, and my general well-being.

1. _____
2. _____

This consent applies until I ask that a name be deleted or a new form replaces this one.

Patient/Guardian Signature: _____

MEDICAL HISTORY

Patient Name: _____

Please check any that apply to your current and past medical history:

☐ AIDS	☐ Epilepsy	☐ Hepatitis	☐ Respiratory Problems
☐ Anemia	☐ Excessive bleeding	☐ Jaundice	☐ Sinus Issues
☐ Arthritis	☐ Fainting	☐ Kidney Disease	☐ Stroke
☐ Asthma	☐ Glaucoma	☐ Liver Disease	☐ Tobacco
☐ Blood Disease	☐ Hay Fever	☐ Mental Disorder	☐ Alcohol use
☐ Cancer	☐ Head Injury	☐ Nervous Disorder	☐ Tuberculosis
☐ Diabetes	☐ Heart Disease	☐ High/Low blood pressure	☐ Tumors
☐ Dizziness	☐ Heart Murmur	☐ Radiation treatment	☐ Ulcers

☐ Pregnancy

Do you have any artificial joints (ex. Knee/Hip/Shoulder/Valve)? ☐ Yes ☐ No

- If YES, please list replacements, treatment date, and your physician:

_____

_____

- If YES, please note that most artificial joints require a pre-med (antibiotic) before dental cleanings and dental treatment.(Based on your medical doctor's recommendation). If you are unsure you are required to take a pre-med, we will need to contact your physician before beginning any dental care.

  Please list the pre-medication prescription you take: _____

Do you have a Pace Maker? ☐ Yes ☐ No

- If YES, when was it placed? _____
- Who is your physician and their office number? _____

Do you have any allergies? ☐ Yes ☐ No

- If YES, please list: _____

Are you currently taking any medications? ☐ Yes ☐ No

- If YES, please list:

  _____

  _____

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 2 years? ☐ 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 my dental healthcare professional at my next appointment without fail.

Signature: _____ Date: _____

INSURANCE AND FINANCIALS

RESPONSIBLE PARTY INFORMATION

Subscribers Name: _____ Subscribers DOB: _____ /_____ /_____

Subscribers Employer: _____Subscribers SSN: _____

Insurance Company Name: _____ Group #: _____

Insurance Company Provider #:_____ ID #: _____

If not self, what is patient's relationship to insured: ☐ Spouse ☐ Child ☐ Other _____

FINANCIAL CONSENT

We are pleased that you have insurance benefits to help you and your family with the cost of your dental care. We would like to help you obtain the maximum use of these benefits. With this in mind, please read the information on our insurance claims process so we can work together to ensure this benefit.

DO YOU ACCEPT MY INSURANCE? HOW MUCH WILL THEY PAY?

We currently accept most private insurance plans. We attempt to maintain computerized histories of payment by a given company, they do change; therefore, it is impossible to give you a GUARANTEED quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is *only an estimate.*

I THOUGHT I PAID MY PORTION, BUT I RECEIVED A BILL. WHY?

We base the patient portion of your bill on our most current date, but there are several factors that can affect this estimate. For example, there may be a deductible, or you may have received treatment in another office prior to joining our office. Insurance companies do not inform us of any charges to your benefits. We do, however, investigate your benefits as thoroughly as possible.

INSURANCE DID NOT PAY, NOW WHAT?

We bill your insurance as a courtesy. Dental insurance is a contract between the employer and the patient. It has no connection at all to us as your dental office. The extent of coverage varies greatly from company to company. It has absolutely nothing to do with the level of service provided by us, and the fee charge for these services. An often-misunderstood term used by many insurance companies is "UCR". This is an arbitrary fee ceiling at which the insurance company will stop reimbursement. These fee ceilings were often set 10-15 years ago. After this ceiling, coverage for a particular procedure may cease, meaning the patient will have an extra portion that is due. Despite our best efforts at giving you an accurate estimate, a patient will occasionally owe the amount of the difference. Again, this has nothing to do with the fee charged but the level of coverage negotiated by the insurance company.

FINANCIAL OPTIONS

We request payment for your portion at the time of service. We do have one financial option that is designed to help you and your family receive the quality of care that you deserve. It is known as CareCredit. It is a credit card for health services.

Please feel free to ask if there is anything we can do to serve you.

CONSENT OF SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read, understand, and accept the terms of the above outline policies for insurance handling and financial commitments that I may incur as a result of treatment and agree to their content.

_____ _____

Patient Signature Date