LINCOLN PLACE DENTISTRY

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Welcome to our practice!

Today's Date _____/_____/_____

First Name _____ Last Name _____

Nickname _____

Birth Date _____/_____/_____ Age _____

Address _____
#, Street, Apt # City State Zip

Home Phone _____

Cell Phone _____

Work Phone _____

Email _____

****Please keep your contact information updated with us at all times, so we may continue to confirm appointments, send statements, and work accurately with your insurance company****

Please circle: Cash Patient (please skip to page 2) Insurance Patient (please continue)

Current dental insurance information if we will be helping file claims on your behalf:

Dental Insurance Carrier _____

Is this insurance through an employer? Name of Employer _____

Subscriber's Full Name _____

Subscriber's Date of Birth _____/_____/_____

Subscriber's Social Security # and Member ID # for Insurance _____

Group # _____

If applicable: Secondary Insurance Carrier _____

Is this insurance through an employer? Name of Employer _____

Subscriber's Full Name _____

Subscriber's Date of Birth _____/_____/_____

Subscriber's Social Security # or Member ID # for Insurance _____

Group # _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking could have an important relationship with the dental care you will receive. Thank you for taking the time to answer all of the following questions.

Are you experiencing any dental problems at this time?

Pain associated w lost filling/broken tooth?	yes / no	If yes, where?_____
Swelling/ Tooth movement / bleeding?	yes / no	If yes, where?_____
Extreme Sensitivity to cold / heat?	yes / no	If yes. where?_____

Do you currently pre-medicate before dental appointments? yes / no

If yes, what do you normally take? _____

Your regular pharmacy and location: _____

Please list any current medications you are taking including oral contraceptives, supplements:

_____

_____

_____

_____

Are you allergic to any of the following? (Please Circle)

Aspirin	Tylenol	Hydrocodone	Acrylic
Metals	Latex	Local Anesthetics	Penicillin

Other:_____

_____

Do you have, or have you ever had any of the following? (Please Circle Any That Apply)

AIDs / HIV Positive	Alzheimer's Disease	Angina	Artificial Heart Valve
Artificial Joint	Asthma/Breathing Problems	Cancer	Chemotherapy
Cold Sores	Diabetes	Drug Addiction	Emphysema
Epilepsy/Seizures	Excessive Bleeding	Fainting Spells/Dizziness	Frequent Headaches
Pacemaker	Heart Disease/Attack	Hepatitis A, B or C	Oral Herpes
High Blood Pressure	Hypoglycemia	Low Blood Pressure	Psychiatric Care
Radiation Treatments	Stomach/Intestinal Disease	Stroke	Tuberculosis

Women: Currently Pregnant Currently Nursing Oral Contraceptives N/A

Due Date if Pregnant: _____

Any serious illnesses not listed above:

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or my dependent's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature: _____ Date _____/ _____/ _____

Please Print name if signing for another party: _____

Financial Policy:

Our fees are due at the time of services rendered. If you're a patient utilizing dental insurance, we will gladly file claims with most insurance companies on your behalf. All patient insurance benefits are to be considered estimates. We will do our best to verify your insurance coverage as accurately as possible, but do not make any guarantees of coverage. It is a patient's responsibility to know and understand their own benefits, eligibility and in-network vs. out-of-network coverages at the time of each appointment. If your insurance is not valid, or refuses to settle a claim in a timely manner (60 days following treatment and/or following the submission of 1 appeal), it will become your responsibility to pay any outstanding balance. If such a situation arises, the patient is responsible to settle any dispute as the insurance provider is not responsible to our office, but to you, the policy holder.

In the event the account becomes past due, you will be charged a $35 service fee and be responsible for all collection fees. You will be responsible for all costs for collection, including, but not limited to attorney fees and court costs. We reserve the right to dismiss you as a patient if your account is sent to collections, or if payments are not received in a timely manner.

Signature:_____ Date _____/_____/ _____

Cancellations:

Each appointment is made specifically for you. We do consider our patients responsible for arriving to any scheduled appointments. We ask that you provide us a minimum of 2 business days notice if you are unable to keep your appointment. When appointments are cancelled with less than 2 business days notice, or an appointment is broken, our office reserves the right to assess a non-refundable fee of $50.00 for cleanings, and $75.00 per hour for dental treatment scheduled.

We reserve the right to reschedule your appointment if you are more than 10 minutes late to your scheduled appointment.

I, _____(print name), acknowledge that I have reviewed the Financial and Cancellation Policies. I agree that I will abide by these provisions and am financially responsible for dental treatment provided at this office.

Signature: _____ Date _____/ _____/ _____
Patient or Responsible Party

Please Print name if signing for another party: _____

"Protected Health Information" = PHI

"Treatment, Payment and Healthcare Operations" = TPO

HIPAA Consent for Contact (Including Confirmation Calls, E-mailing Statements, Etc.)

Patient Consent for Use and Disclosure of Protected Health Information:

- With my consent, designated Lincoln Place Dentistry personnel may use and disclose PHI about me to carry out TPO.
- With my consent, Lincoln Place Dentistry may call my home, cell phone or work phone provided and leave a message on voicemail or in person in reference to any actions that assists Lincoln Place Dentistry personnel in carrying out TPO, such as appointment confirmations, insurance questions or clinical care.
- With my consent, Lincoln Place Dentistry personnel may mail to my home or other provided address any items that will assist in carrying out TPO, such as PHI, confirmation cards and statements.
- With my consent, Lincoln Place Dentistry personnel may send standard e-mails of any items that assist in carrying out TPO, such as PHI, appointment confirmations and patient statements.

By signing below, I am consenting to Lincoln Place Dentistry's use and disclosure of my PHI to carry out TPO. If I do not sign this consent, Lincoln Place Dentistry may decline to provide treatments to me, forward insurance claims on my behalf, or provide protected PHI to sources outside of the Lincoln Place Dentistry organization. I also acknowledge that I understand that statements may be addressed to the primary account holder (primary insurance holder) on the account, which may differ from the patient who has received services. I will let Lincoln Place Dentistry know if I cannot have billing completed in this manner.

Signature: _____ Date _____/_____/ _____

HIPAA Permission to Contact Your Insurance Company, Physicians, other dentists and Specialists regarding your Care: Patient Authorization to release PHI to Third Parties.

By signing this authorization, I authorize Lincoln Place Dentistry personnel to use and/or disclose certain PHI about me to parties necessary to complete TPO; this may be accomplished by telephone, mail, standard e-mail, or via fax. When my information is used to the disclosed pursuant to this authorization, it may be subjected to redisclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule.

Signature: _____ Date _____/_____/ _____

Please Print name if signing for another party: _____