

New Image General Dentistry

Patient Information

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

Address: _____
Street City/State Zip code

Gender: (M or F) _____ Marital Status: Single Married Divorced Widowed DOB: _____

Whom may we thank for referring you? _____ Email _____

Phone (Home) _____ Phone (Work): _____ Ext: _____ Cell # _____

Best time to call _____ SS#: _____ Occupation: _____

Emergency Contact: Name _____ Address _____ Tele# _____

Insurance Information

Subscriber Name _____ SS# _____ DOB _____

Insurance Company _____ Group Number _____ Phone _____

Mailing Address _____ Employer _____

Effective Date _____ Coverage: Individual _____ Spouse _____ Children _____

Responsible Party

Person responsible for the account _____ Relationship _____

Address: _____
Street City/State/Zip Code

Home Phone # _____ Work # _____ Cell # _____

Health Information

Physician's Name _____ Address _____

Telephone # _____ Date of Last Physical _____

Any Known Drug Allergies? _____

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

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Anaphylactic Rxns | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HIV Positive/AIDS | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Taking Aspirin | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Tuberculosis |

Do you need to pre-medicate before your appointments? _____ Are you currently taking any over-the-counter or prescription medication? _____ If so, please list them _____

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Patient Information

Dental Information

What is the reason for this visit? _____

How long since your last dental visit? _____

Previous dentist's name and address: _____

Why did you leave your previous dentist? _____

When were X rays last taken of your teeth? _____

How frequently do you brush your teeth? _____

Soft or Hard bristle toothbrush? _____

Yes No Do you have any concerns regarding your teeth?

Yes No Have you lost any teeth?

Yes No Do you clench or grind your teeth?

Yes No Do you have any tooth, jaw, or muscle discomfort?

Yes No Do you have frequent headaches?

Yes No Do you have a click, pop, or other noise in the jaw joint?

Yes No Are your teeth sensitive to hot or cold?

Yes No Are any of your teeth uncomfortable to bite on?

Yes No Do your gums bleed when brushing or flossing your teeth?

Yes No Would you like information on whitening your teeth?

Yes No Are you interested in cosmetic bonding or straightening your teeth?

Are there any conditions or concerns about your health that we need to discuss that have not been covered in this questionnaire? _____

I hereby authorize the release of any information, including the diagnosis and records of any treatments, X rays, photographs, or examinations rendered, to my insurance company. I hereby authorize my insurance company to pay directly to New Image General Dentistry any proceeds payable under the terms of my insurance policy. I understand that I am responsible for my dental bills. I hereby authorize _____ to perform dental procedures on me, my minor children and/or family members. I will inform _____ of any changes in my health.

Signature _____ Relationship _____ Date _____

Your Rights

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law and prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have a right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have a right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to the Secretary of Health and Human Services or us if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Your signature below is an acknowledgement that you have received this Notice of our Privacy Practices.

Print Name: _____ Signature: _____ Date: _____

New Image General Dentistry

Office Financial Policy

Thank you for choosing New Image General Dentistry and Luis Carrero, DMD, to provide you with dental care. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment.

- I understand that I am responsible for all fees related to my dental care and treatment.
- I understand that full payment for all dental work is to be paid at the time of treatment. (Less any **estimated** insurance coverage)
- I understand that any and all account balances over 30 days old may be subject to a monthly interest charge, at the maximum allowed legal fees.
- I understand that if a check, electronic authorization or debit sent or provided to the office for payment is not honored, I will be charged the maximum allowed penalty.
- I understand that if my account is not paid in a timely manner (30 days), my account may be turned over to a collection agency. In addition to paying balances, I agree to pay all reasonable attorneys' fees, collection and/or court costs and a monthly interest charge at applicable maximum legal rates.
- I understand that it is my responsibility to notify the office of any changes in address, phone numbers, work contact information and status, insurance changes, etc.
- We accept cash, checks, Visa, MasterCard, Discover, American Express and Care Credit.
- **Cancelled or failed appointments with less than 24 hours notice will be charged a fee of \$25 to your account. \$50 for Saturday appointments.** (Please notify our office in advance for all necessary cancellations)

Insurance

- I understand that it is solely my responsibility to confirm with my insurance company which treatment or procedures are covered, whether or not there are exclusions, deductibles, annual or lifetime deductibles.
- I understand the insurance estimate may differ from what my insurance carrier ultimately pays and that I am ultimately responsible for any and all balances, even if my insurance company agrees to pay and later denies any portion of the claim.
- I understand that as a courtesy New Image General Dentistry will send my claim to my insurance company. If my insurance company fails to pay within 90 days. I will be fully responsible for the balance on my account and payment is due with 30 days of the statement date.

Our office strives to provide quality, dependable and esthetic dental care. The "least" expensive insurance solution is seldom in the best interest of the patient's health. It is important to understand that insurance companies draw all contracts with the patient's employer. Their plan may not fit your overall dental health requirements.

Keep in mind some procedures have restricted frequencies, as to how often they can be performed. The insurance company is not competent to diagnose, but they can apply their rules to the policy. Any payment denial reflects only the insurance company's resistance to pay and not lack of need for the rendered treatment. Full payment is still required.

We will do our best to give you as much information as we can about your coverage regarding your treatment, however when your insurance is verified, limited and basic information is given to us.

I have read, understand and agree to the above office financial policies.

Signature of Patient or Guardian

Date