Hunsaker Dental

PATIENT REGISTRATION AND FINANCIAL POLICY

First Name: _____ Middle Initial _____ Last Name: _____

Preferred Name: _____ Date of Birth: _____ Patient SSN: _____

Address: _____ Apt_____ City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Sex: M F Marital Status: M S D Sep

Email: _____ How you heard about us: _____

Primary Insurance: Company: _____ Group no. _____ Policy no. _____

Subscriber Name: _____ SSN: _____ Phone: _____

Date of Birth: _____ Employer: _____

Secondary Insurance: Company: _____ Group no. _____ Policy no. _____

Subscriber Name: _____ SSN: _____ Phone: _____

Date of Birth: _____ Employer: _____

Payment for service: Payment is due at the time of service. Partial payment will not be accepted unless otherwise arranged in advance. **Please be aware that if a balance remains unpaid, we will refer you to an external collections agency, and your account will be charged a $125.00** collection fee. At that point you will be discharged from the practice.

Insurance: As a courtesy, we will bill your primary and secondary insurance companies. Estimates will be given to the best of our ability based on your individual policy for any service rendered. Estimated patient portions must be paid at the time of service. Please be aware that some or all of the services you receive may not be covered by your insurance. **It is your responsibility to know which services your insurance will cover and how much they will pay for them.** We are happy to assist you in finding out what your coverage includes. **Any insurance payment quotes are an estimate and are NOT a guarantee of payment. You will be responsible for any balance not covered by your insurance. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.** Any questions regarding details of your coverage should be directed to your insurance carrier. We allow 90 days for your insurance company to pay your claim. After this time, you will be responsible for payment of any outstanding balances, and for further efforts to receive insurance payment.

To confirm your insurance eligibility and to submit insurance claims, we must have a copy of your current insurance card. We will also require the policy holder's information, including name, date of birth, social security number, and employer who is providing the insurance. If we do not receive this information in its entirety, your insurance carrier will not be billed and you will be responsible for the full cost of all services provided.

Missed Appointments and Returned Checks: Any appointment that is cancelled or rescheduled within 48 hours is subject to a $25.00 missed appointment fee. Surgical appointments require 72 hours advanced cancellation notice, and are subject to a $75.00 missed appointment fee. These charges are your responsibility and will be billed directly to you. **All returned checks will be subject to an external collection service, and a minimum fee of $50.00 will be assessed for bank penalty charges incurred**. You will also be charged the cost of certified mailing in addition to the amount of your returned check.

Credit Balance: In the event that there is an overpayment that results in a credit balance on the account, all balances will remain on the account to be applied to future visits unless otherwise arranged for a refund. Refund requests must be made in writing.

Authorization, Release, and Agreement to Pay: ***I understand that before I receive any service at Hunsaker Dental, I must read and agree to this financial policy in its entirety.*** I authorize and hereby request my insurance company to pay directly to Hunsaker Dental any insurance benefits for services rendered at Hunsaker Dental. I understand that my dental insurance carrier may pay less than the actual fees for services. I agree to be responsible for all charges for dental services and materials not paid by my dental benefits plan. **If I do not pay the entire new balance within 90 days of the date of service, a finance charge of 1.5% per month (18% annually) will be assessed to my account, in addition to monthly billing charges.** I realize that failure to pay my account will result in further action and that Hunsaker Dental will be unable to provide additional dental services on behalf of me and/or my dependents until such time as the account is paid in full. Any future services from that point on will be cash paid in full due at the time of service. In the event that I do not pay according to this agreement, I agree to pay collection costs and reasonable attorney fees associated with Hunsaker Dental's efforts to collect on this amount or any outstanding account balances. I agree to be responsible for payment of all services rendered on behalf of myself or my dependents.

I have read the above. I fully understand and accept the terms and conditions set forth.

Patient Name: _____ Date: _____

Signature of patient or responsible party: _____

Hunsaker Dental

HIPAA Consent and Authorization

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides privacy protections to your medical records. Our benefits office (or other third party designated by our office) may sometimes need to disclose medical information or payment information protected by HIPAA in relation to our group health plans to your family members or close friends involved in your health care. For example, your spouse may need to contact us if you are in the hospital to determine whether a particular procedure is covered under our group health plan or may need assistance filing a claim for medical services. Under HIPAA, unless you specifically object, we are allowed to use our professional judgment in deciding whether to discuss your medical and payment information with your family members or close friends. However, we would like to provide you with the opportunity to tell us with whom we may discuss your medical or payment information under our group health plans.

You may communicate with the following individual(s) relating to my medical or payment information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☐ **Do not discuss my medical or payment information with anyone other than myself**

I authorize the professional office of Hunsaker Dental to release health information identifying me under the following terms and conditions:

1. At times, it may be necessary to provide the patient's name and any applicable tooth number or numbers for needed treatment. No other identifying information is provided to outside providers
2. Information if released as stated above, to dental laboratories or other providers of dental care that may be involved in the continuing care of our patients
3. Information is released during the course of treatment for patients. Instances where this may be required is in the referral of patients to other providers, fabrication of permanent crown and bridge work, fabrication of dentures and partials, as well as the fabrication of other oral appliances.
4. There is no expiration date for this release and it is current through the course of treatment for the patient

I acknowledge that I have read and been offered a copy of the Notice of Privacy Practices.

Print Patient Name: _____ Date: _____

Patient or legal Guardian Signature: _____

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 of the following:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Specify) _____

Hunsaker Dental

DENTAL HISTORY

Patient Name: _____ Date: _____ Birthdate: _____

Please answer the following questions in order to help us better serve you.

What is the reason for your visit today? _____

Are you experiencing any dental pain or discomfort? ☐Yes ☐No If yes: _____

Are any of your teeth sensitive to: ☐Hot ☐Cold ☐Sweets ☐Pressure

Have you noticed any mouth odors or bad tastes? ☐Yes ☐No

Does food get caught in your teeth? ☐Yes ☐No

Do you have a problem with dry mouth? ☐Yes ☐No

Do you clench or grind your teeth? ☐Yes ☐No

Do you have problems with your jaw joint?

☐Pain ☐Sounds ☐Locking ☐Popping ☐Limited Opening

Do you have any missing teeth? ☐Yes ☐No

If yes, which replacement options appeal most to you?

☐Dentures ☐Partials ☐Implants ☐Bridges ☐Other

Is there anything about the appearance of your teeth that you would like to change?

☐Spacing ☐Crowding ☐Rotated Teeth ☐Overbite ☐Shape of teeth

☐Color of teeth ☐Other ☐I'm happy with my teeth

Do you, or have you ever been told that you snore? ☐Yes ☐No

Have you ever been diagnosed with sleep apnea ☐Yes ☐No

Do you use, or have you ever used a CPAP Machine? ☐Yes ☐No

If yes, do you like your CPAP? ☐Yes ☐No

How often do you brush your teeth?

☐Twice per day or more ☐Once per day ☐Once every 2-3 days ☐Once per week

☐Once per month ☐Rarely ☐Never

How often do you floss?

☐Once or twice per day ☐A few times a week ☐Once per week ☐Once or twice per Month

☐Rarely ☐Never

Do you use any oral care item? ☐Yes ☐No If yes: _____

Do you have trouble cleaning or caring for your teeth? ☐Yes ☐No If Yes: _____

Have you ever had trouble getting numb or had

any reactions to local anesthetic? ☐Yes ☐No If yes: _____

Do you feel nervous about dental treatment? ☐Yes ☐No If yes: _____

Do you have any other dental concerns or comments not listed? _____

Hunsaker Dental

MEDICAL HISTORY

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 interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐Yes ☐No If yes: _____

Have you ever been hospitalized or had a major operation? ☐Yes ☐No If yes: _____

Have you ever had a serious head or neck injury? ☐Yes ☐No If yes: _____

Are you taking any medications, pills, or drugs? ☐Yes ☐No If yes: _____

Do you take, or have you taken, Phen-Fen or Redux? ☐Yes ☐No If yes: _____

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing Bisphosphonates? ☐Yes ☐No If yes: _____

Are you on a special Diet? ☐Yes ☐No If yes: _____

Do you use tobacco products? ☐Yes ☐No If yes: _____

Women: Are you: ☐Pregnant/Trying to get Pregnant ☐Nursing ☐Taking oral contraceptives

Are you allergic to any of the following?

☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex

☐Sulfa Drugs ☐Local Anesthetics ☐Other: _____

Do you use controlled substances? ☐Yes ☐No If yes: _____

Do you have, or have you had, any of the following?

Aids/HIV Positive	☐Yes☐No	Cortisone Medicine	☐Yes☐No	Hemophilia	☐Yes☐No	Radiation Treatments	☐Yes☐No
Alzheimer's Disease	☐Yes☐No	Diabetes	☐Yes☐No	Hepatitis A	☐Yes☐No	Recent Weight Loss	☐Yes☐No
Anaphylaxis	☐Yes☐No	Drug Addiction	☐Yes☐No	Hepatitis B or C	☐Yes☐No	Renal Dialysis	☐Yes☐No
Anemia	☐Yes☐No	Easily Winded	☐Yes☐No	Herpes	☐Yes☐No	Rheumatic Fever	☐Yes☐No
Angina	☐Yes☐No	Emphysema	☐Yes☐No	High Blood Pressure	☐Yes☐No	Rheumatism	☐Yes☐No
Arthritis/Gout	☐Yes☐No	Epilepsy or Seizures	☐Yes☐No	High Cholesterol	☐Yes☐No	Scarlet Fever	☐Yes☐No
Artificial Heart Valve	☐Yes☐No	Excessive Bleeding	☐Yes☐No	Hives or Rash	☐Yes☐No	Shingles	☐Yes☐No
Artificial Joint	☐Yes☐No	Excessive Thirst	☐Yes☐No	Hypoglycemia	☐Yes☐No	Sickle Cell Disease	☐Yes☐No
Asthma	☐Yes☐No	Fainting/Dizziness	☐Yes☐No	Irregular Heartbeat	☐Yes☐No	Sinus Trouble	☐Yes☐No
Blood Disease	☐Yes☐No	Frequent Cough	☐Yes☐No	Kidney Problems	☐Yes☐No	Spina Bifida	☐Yes☐No
Blood Transfusion	☐Yes☐No	Frequent Diarrhea	☐Yes☐No	Leukemia	☐Yes☐No	Stomach/Intestinal Disease	☐Yes☐No
Breathing Problems	☐Yes☐No	Frequent Headaches	☐Yes☐No	Liver Disease	☐Yes☐No	Stroke	☐Yes☐No
Bruise Easily	☐Yes☐No	Genital Herpes	☐Yes☐No	Low Blood Pressure	☐Yes☐No	Swelling of Limbs	☐Yes☐No
Cancer	☐Yes☐No	Glaucoma	☐Yes☐No	Lung Disease	☐Yes☐No	Thyroid Disease	☐Yes☐No
Chemotherapy	☐Yes☐No	Hay Fever	☐Yes☐No	Mitral Valve Prolapse	☐Yes☐No	Tonsillitis	☐Yes☐No
Chests Pains	☐Yes☐No	Heart Attack/Failure	☐Yes☐No	Osteoporosis	☐Yes☐No	Tuberculosis	☐Yes☐No
Cold Sores/Fever Blisters	☐Yes☐No	Heart Murmur	☐Yes☐No	Pain in Jaw Joints	☐Yes☐No	Tumors or Growths	☐Yes☐No
Congenital Heart Disorder	☐Yes☐No	Heart Pacemaker	☐Yes☐No	Parathyroid Disease	☐Yes☐No	Ulcers	☐Yes☐No
Convulsions	☐Yes☐No	Heart Trouble/Disease	☐Yes☐No	Psychiatric Care	☐Yes☐No	Venereal Disease	☐Yes☐No
						Yellow Jaundice	☐Yes☐No

Have you ever had any serious illness not listed? ☐Yes ☐No If yes: _____

Comments: _____

_____

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 the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or guardian: _____

Printed Name: _____ Date: _____