

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)

Do you wear contact lenses? Yes No DK

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Yes No DK

Date: _____ If yes, have you had any complications? Yes No DK

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax[®], Actonel[®], Atelvia, Boniva[®], Reclast, Prolia) for osteoporosis or Paget's disease? Yes No DK

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia[®], Zometa[®], XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes No DK

Date Treatment began: _____

Allergies. Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction. Yes No DK

Local anesthetics Yes No DK

Aspirin Yes No DK

Penicillin or other antibiotics Yes No DK

Barbiturates, sedatives, or sleeping pills Yes No DK

Sulfa drugs Yes No DK

Codeine or other narcotics Yes No DK

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Artificial (prosthetic) heart valve Yes No DK

Previous infective endocarditis Yes No DK

Damaged valves in transplanted heart Yes No DK

Congenital heart disease (CHD)

Unrepaired, cyanotic CHD Yes No DK

Repaired (completely) in last 6 months Yes No DK

Repaired CHD with residual defects Yes No DK

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Cardiovascular disease Yes No DK

Angina Yes No DK

Arteriosclerosis Yes No DK

Congestive heart failure Yes No DK

Damaged heart valves Yes No DK

Heart attack Yes No DK

Heart murmur Yes No DK

Low blood pressure Yes No DK

High blood pressure Yes No DK

Other congenital heart defects Yes No DK

Mitral valve prolapse Yes No DK

Pacemaker Yes No DK

Rheumatic fever Yes No DK

Rheumatic heart disease Yes No DK

Abnormal bleeding Yes No DK

Anemia Yes No DK

Blood transfusion Yes No DK

If yes, date: _____

Hemophilia Yes No DK

AIDS or HIV infection Yes No DK

Arthritis Yes No DK

Do you use controlled substances (drugs)? Yes No DK

Do you use tobacco (smoking, snuff, chew, bidis)? Yes No DK

If so, how interested are you in stopping? Very Somewhat Not interested

Circle one: VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? Yes No DK

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

WOMEN ONLY Are you:

Pregnant? Yes No DK

Number of weeks: _____

Taking birth control pills or hormonal replacement? Yes No DK

Nursing? Yes No DK

Metals Yes No DK

Latex (rubber) Yes No DK

Iodine Yes No DK

Hay fever/seasonal Yes No DK

Animals Yes No DK

Food Yes No DK

Other Yes No DK

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes No DK

Name of physician or dentist making recommendation: _____ Phone: *include area code* () _____

Do you have any disease, condition, or problem not listed above that you think I should know about? Yes No DK

Please explain: _____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

Hollymead Dental Arts

Insurance Information:

Policy Holder: _____

Patient Relation: _____

Policy Holder's DOB: _____

Policy Holder's SS#: _____

Policy Holder's
Employer _____

Insurance
Company _____

Insurance Address _____

Insurance Phone Number _____

Group # _____

Policy (ID) # _____

How did you hear about us?

*Dentist _____

*Advertisement _____

*Insurance Carrier _____

*Family/Friend _____

*Other _____

**Financial Agreement
For the office of
Hollymead Dental Arts**

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care, using only the highest quality materials and technology available in the market today. We are also committed to providing you with up to date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative cost.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employer and the insurance company. Our practice is not a party to that agreement. If payment from your insurance company is not received within 30 days from the date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all of your insurance claims. You may direct your insurance company to pay your benefits directly to our practice by signing the authorization on the assignment of benefits agreement. In order for your practice to file your insurance claim, you must bring a completed dental insurance form or proof of insurance at each appointment.

Your estimated copayment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. Your estimated copayment may be adjusted after the time of treatment depending upon the final reconciliation of the insurance payments. Our practice accepts cash, money orders, personal checks, Visa, MasterCard, Discover, American Express and Flex spending cards for payment. Third party, extended payment financing is available upon request and approval with CareCredit.

Returned checks and balances older than 31 days will be subject to collection fees, finance charges at the rate of 1.5% per month (18% annually). An account over 31 days with a balance pending is your responsibility and we request you follow up with your insurance company. Accounts over 60 days will be subject to our collection agency for further legal processing.

Additionally, our practice may charge you for appointments that you do not keep and for appointments that you do not cancel within 24 hours business day notice. Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care.

PRINT NAME (PATIENT)

SIGNATURE OF RESPONSIBLE PARTY

DATE

Assignment of Benefits
For the office of
Hollymead Dental Arts

Our practice will accept an assignment of benefits from your insurance company with the conditions 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 all treatment and services we provide to you, regardless of the amount that may or 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 practice from your insurance company. By having our practice process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- ❖ We require you to 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 practice.
- ❖ We require you to pay the estimated copayment, which is the amount not covered by your insurance company at the time we provided service to you. The copayment 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 days from the time of billing. If your insurance company has not made payment to our practice within 30 days, we will ask you to pay the entire balance at that time. You will be responsible for seeing reimbursement from your insurance company at that time.
- ❖ Our practice does not guarantee that your insurance company will pay for treatment that you receive from our practice. We perform routine 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 practice 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 to our practice.

WE DO NOT FILE WORKMANS COMP.

I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THIS ASSIGNMENT OF BENEFITS AGREEMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO HOLLYMEAD DENTAL ARTS.

PRINT NAME (PATIENT)

SIGNATURE OF RESPONSIBLE PARTY

DATE

HIPAA ACKNOWLEDGEMENT/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.

Print Patient Name _____

Signature _____

Signature Date _____

Relationship to Patient (if patient unable to sign) _____

I give my permission for my protected health information to be disclosed for purpose of communicating results, findings, and care decisions to the individuals listed below. I understand I can add or remove any individuals at any time.

| Name | Relationship | Phone number |
|------|--------------|--------------|
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