Patient Name____ **Preferred Name**______________________
(First) (M.I.) (Last)

Street Address ____**Apt.**_________________________

City______________________________________**State**_________**Zip**___________________________________

Home #:________________________ **Cell #:**___________________________ **Work#:** ____________________

Sex: M F Age_____ **Birthdate** ______/______/______ **Single/Married/Separated/ Divorced/Widowed/Child**

Parent/Responsible Party Name ____
(If applicable)

Employer___________________________________ **Occupation**______________________________________

Do you have a Gmail account?_________________________ **E-mail**___________________________________

Patient SS#_______-_______-_______ **Parent/Responsible SS#**_______-_______-______ **DOB**____________

Primary Dental Insurance Carrier________________________**Group Policy #**_________________________

Subscriber:___________________________**DOB:**__________________**ID#:**____________________________

Secondary Dental Insurance Carrier_____________________**Group Policy #**___________________________

Subscriber:___________________________**DOB:**__________________**ID#:**____________________________

How did you hear about us?____

Reason for Appointment____

Medical History

Physicians Name_____________________________________Last Seen________________________________

Are you under a physician's care?____________For what?____

Have you ever had any of the following? (Please circle)

Heart Murmur	**Blood Disease**	**Cancer**
Diabetes	**Asthma**	**Seizures**
Mitral Valve Prolapse	**Respiratory Disease**	**Thyroid Disease**
Hepatitis or Liver Problems	**Heart Attack**	**Nervousness/Depression**
High Blood Pressure	**Stroke**	**Kidney Problems**
Other:_________________________________		**Latex Allergy**

Do you have any drug allergies?_______ If so, what____

List any current Medications:____

Do you need to pre-med before appointments? Y / N If yes, for what?_____________________________________

(Women) Are you Pregnant? Y or N Are you currently nursing? Y or N

Last Dental Visit_________________________ For What____

_____________________________ ___________ ____

Patient Signature (Parent if child) **Date** **Dentist Signature**

FINANCIAL POLICY

Thank you for choosing our office for your dental needs. We are committed to providing you with the highest quality dental care possible and look forward to building a relationship with you. So that we may better serve you, we require our patients to read, understand and sign our financial policy prior to receiving treatment.

- Payment of your bill is considered part of your treatment
- Payment is due at the time of service unless prior arrangements have been made.
- For a co-pay of $500 or more, a deposit of half is required to schedule an appointment, with the other half due at the appointment.
- Any and all forms of Sedation appointments require payment in full at time of scheduling.
- We accept cash, check, MasterCard, Visa, Discover, and American Express. We also offer Care Credit as an outside financing option.
- Returned checks will be subject to a Return Check Fee of $35.
- A $25 fee will be applied for appointments cancelled/broken with less than 24-hours notice (effective 10/2/14).

If you have dental insurance, we will file your claims for you as a courtesy. We will provide an insurance ***estimate*** for you, and do everything we can to ensure it is as accurate as possible. An **estimate** is not a guarantee of payment. The patient is responsible for anything not covered by insurance, up to the full amount of the treatment cost. All charges incurred by the patient are the patient's responsibility regardless of insurance coverage.

We will comply with any regulations and requests made by your insurance company to assist in claim payment. However, any claims not paid within 90 days will be billed directly to the patient.

Thank you again for the opportunity to serve your dental needs. Please feel free to ask any questions you may have regarding your care or our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO FREEDOM FAMILY DENTISTRY. I understand that responsibility for payment for services provided in this office for myself or dependants is mine, due at time of service unless prior financial arrangements have been made. I also understand that a finance, collection charge and/or attorney fee will be added to any overdue balance.

____ ___________________________

Patient signature (Parent/Guardian if a minor) Date

____

Patient name (Please Print)

Authorization for Release of Information:

Name of Patient ____ Date of Birth ______________

Freedom Family Dentistry is authorized to release protected health information about the above named patient in the following manner and to identified persons.

I, _______________________________, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

Please print name:	Relationship:	Information to be released:
____	____________________________	____________________________________
____	____________________________	____________________________________
____	____________________________	____________________________________

I give Freedom Family Dentistry permission to do the following (please initial all that apply):

____ Email X-rays and clinical notes to myself or another medical provider to whom I may be referred.

____ Post my name/photo to their social media sites

Patient Rights:

- I have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.
- I have the right to revoke this authorization, in writing, at any time. Such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent but will be effective going forward. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

By signing this form, you consent to our use and disclosure of protected health information about you for your treatment, payment and healthcare operations.

This authorization will remain in effect until revoked by the patient.

____Date ___________________

Signature of Patient or Personal Representative *Description of Personal Representative's Authority (attach necessary documentation)

For Office Use Only:

_____Patient refused to sign Authorization. Patient has the right to refuse. USPS or patient pick up will be used for PHI transfer.

Office Staff Signature:________________________ Printed Name:_________________________ Date:________________

Witnessed Staff Signature:____________________ Printed Name:_________________________ Date:________________

Freedom Family Dentistry

CONTRACT

The undersigned understands that Medical/Dental insurance claims may be billed by the provider, as a courtesy, if the provider participates with the insurance plan, and if the patient promptly furnishes the provider with all correct insurance information. The undersigned is fully responsible for all sums due whether or not insurance coverage is available. If the undersigned fails to promptly pay for the services rendered, the undersigned authorizes the release by or to any credit reporting agencies of personal credit information on the undersigned. In consideration for the professional services rendered now and in the future, the undersigned hereby agrees to pay attorney's fees which are hereby stipulated to be 33 1/3% of such outstanding balance whether suit is filed or not; plus court costs.

In the absence of prompt payment, the undersigned understands that medical, personal and financial records concerning these professional services will be released to the provider's attorney for collection. The attorney will act as the providers "Business Associate" in compliance with the federal "Health Information Portability and Accountability Act."

I, the undersigned, certify that I _____ **am** an Active Duty Member of the U.S. Armed Forces.

_____ **am not** an Active Duty Member of the U.S. Armed Forces.

____ __________________________

Patient signature (Parent/Guardian if a minor) Date`

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name: ____

Legal Guardian's Name: _________________________________

Patient Address: _______________________________________
____

I have received a copy of the Notice of Privacy Practices for the above named practice.

______________________________ ____________________

Signature of Patient or Legal Guardian Date

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent by requesting a copy from the receptionist. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.