Welcome! Thank you for selecting our oral healthcare team! We will strive to provide you with the best possible care. To help us meet all your healthcare needs, please fill out this form, completely, in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Patient Information (Confidential)

_____ ____/___/____
Patient Name Age ☐ Male ☐ Female Date of Birth

_____
Address City State Zip

(_____) _____ (_____) _____
Home Phone Cell Phone Email SS# **(required if utilizing insurance)**

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

_____ (_____) _____
Occupation Employer Work Phone

_____
If a Full Time Student, Name of School/College/University City State

_____ (_____) _____
Person to contact in case of emergency Relation to patient Phone

Referral Information (Whom may we thank for referring you?)

Referred By _____(_____) _____
Phone

_____ (_____) _____
Name of Primary Care Physician Office Phone

Authorization to Release Protected Health Information

Patients may authorize the release of information from their medical/financial records to any designated person(s) they choose. If you would like to give someone permission to access your chart information, please fill out the information below:

"I authorize Reform Dentistry to release medical/financial information from my personal records to the following person(s), and I understand that I may revoke this authorization at any time by written request ONLY."

Name _____ Relation to Patient _____ Date ____/____/_____

Name _____ Relation to Patient _____ Date ____/____/_____

Patient's/Guardian's Signature _____ **Date** ____/____/_____

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. This information is found on both sides of the clipboard. If you have any questions regarding this form, please ask to speak with our HIPAA Compliance Officer in person or by phone. Signature below is only acknowledgement that the Notice of our Private Practices has been made available to you.

_____ _____/_____/_____
Print Name Signature Date

Patient Medical History (Please fill out completely)

- Are you under medical treatment now?.....Yes_ No_
  Or within the past year?..... Yes_ No_
- Are you taking any drugs or medications?..... Yes_ No_
  Or within the past year?..... Yes_ No_
  If yes, what?_____
- Have you ever had a major operation?..... Yes_ No_
- Have you ever had any complications during or after an operation, anesthetic, or tooth extraction?..... Yes_ No_
- (Women only) Are you pregnant at this time or think you might be?..... Yes_ No_
  Are you nursing?..... Yes_ No_
- Are you wearing contact lenses?..... Yes_ No_
- Are you allergic to or have had any reactions to the following?
  Penicillin or any other antibiotics..... Yes_ No_
  Codeine..... Yes_ No_
  Local Anesthesia(e.g. Novacaine)..... Yes_ No_
  Other (please list)..... Yes_ No_
  _____
- Do you have a cough or cold?..... Yes_ No_
- Did someone come with you to drive you home? ..... Yes_ No_
- Have you had anything to eat or drink within the last six hours?..... Yes_ No_

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

_ Heart Disease	_ Epilepsy	_ Asthma	_ Stomach Problem
_ Blood Disorder	_ Arthritis	_ Anemia	_ Venereal Disease
_ Liver Problem	_ Aids	_ Sinus Trouble	_ Emphysema
_ Stroke	_ Kidney Disease	_ Hepatitis	_ Lung Problem
_ Glaucoma	_ Cancer	_ Cirrhosis	_ High Blood Pressure
_ Rheumatic Fever	_ Tuberculosis	_ Diabetes	_ Psychiatric Treatment
_ Immune Disorder	_ Yellow Jaundice	_ Heart Murmur	_ Liver Trouble
_ Breathing Problem	_ HIV Positive	_ Leukemia	_ Prolonged Bleeding

Have you had any other serious illness? ..... Yes_ No_
If yes, what?
_____
_____
_____

~I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I agree to be responsible for the payment of all services rendered on my behalf or my dependents.

_____
Please print your name...

_____
Signature of Patient (or Parent/Legal Guardian, if minor) Date

A WORD ABOUT OUR PAYMENT POLICY:

Thank you for choosing us for your oral surgery needs. We are committed to providing quality and affordable oral healthcare, and we feel that everyone benefits when there is a clear and definitive financial policy given to our patients prior to treatment. Please read, complete the requested information, and sign in the space provided. A copy will be provided to you upon request. You may also request an estimate of your charges prior to treatment.

Method of Payments:
To make your financial obligations as easy as possible we accept the following methods of payment: Cash, Visa, MasterCard, American Express, and Discover. For financing, ask about our monthly payment plans.

Insurance:
We participate with many insurance plans. If you are not insured by a plan that we participate with, payment in full is expected at each visit. If you are insured by a plan that we participate with but do not have your insurance card with you, or missing a required referral, payment in full is expected for each visit until we can properly verify your coverage. Please contact your insurance with any questions you may have regarding coverage. We will assist you as we can, but knowing your insurance coverage is ultimately your responsibility.

Utilizing Your Insurance Benefits:
Patients who wish to utilize their insurance benefits must complete our patient registration form (separate page) and our payment policy form (see other side), completely, before seeing the doctor. We require the following information if you wish to use your insurance coverage for your procedure:

- **A copy of the Patient's (and/or Legal Guardian) valid driver's license.**
- **Social security number of the Patient (and/or Legal Guardian).**
- **A copy of the current valid insurance card of the Subscriber.**

Patients who do not have this information available, or prefer not to supply us with this information will be considered self-pay patients. Payment in full (cash or credit only) will be expected prior to treatment. We understand our patient's concerns for privacy of their personal information and medical records. Our practice fully complies with HIPAA regulations set by the Federal Government. Requiring the above information with insurance utilization protects our patients and our practice from possible cases of identity fraud. If you still choose to opt out of supplying us with the required information, we will supply you with the necessary information needed in order for you to file to your insurance and be reimbursed by them directly.

Claims Submission:
We make every effort to keep down the costs of care for all our patients. We will assist you in any way we reasonably can to help get your claim paid. Your insurance may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that your account balance is your responsibility whether or not the insurance pays on your claim. Any coverage given by your insurance is an estimate and not a guarantee of coverage or payment. Any information our staff gives regarding a patient's insurance coverage is strictly a courtesy, and not a contract of responsibility. Your insurance is a contract between you, your employer, and the insurance company; we are not a party to that contract.

Copayments and Deductibles:
For those patients who have been verified for coverage, all copayments and applicable deductibles must be paid at the time of service. This arrangement is part of your signed contract with the insurance company, and failure to pay the co-payments can be considered fraud. Please help us in upholding the law by being prepared to pay your co-payment in full at the time of treatment.

Non-Covered Services:
Please be aware that some – and perhaps all – of the procedures you receive may not be covered or not considered reasonably necessary by your insurance. Any procedure not covered, whether it be partially denied or fully, will be the responsibility of the patient. Payment in full will be expected at the time of treatment, or once the patient's claim has been processed and returned.

Nonpayment:
Any balance still due after 90 days will become your responsibility whether or not insurance has processed your claim, and payment will be expected in full within the next 30 days. Partial payments will not be accepted unless otherwise arranged by our billing department. Any balance still due on an account after 120 days will be eligible for collections, and will be charged a finance charge of 1% each month until paid in full. Those accounts that are eligible for collections activity will be turned over to an attorney and/or collections agency for processing. The patient and/or legal guardian will then be responsible for ALL reasonable attorney and/or collection agency fees that will be charged in addition to the balance on the account. In the event of a returned check, there will be a $35 bank fee charged to your account, and payment in full must be made within 10 days of the returned check to avoid additional collection activity mentioned previously.

(Please initial _____ and continue on back)

Account Guarantor (must be present for signature, at time of appointment)

Patient Name: _____

_____/_____/_____
Name of Person financially responsible (if other than patient) Relation to Patient Date of Birth

Address _____ City _____ State ____ Zip _____

Email _____ Home Phone (____) _____ - _____ Cell Phone (____) _____ - _____

Driver's License # _____ SS# (Required if utilizing Insurance) _____ - _____ - _____

Name of Employer _____ Work Phone (____) _____ - _____

Is this person currently a patient in our office? ☐ YES ☐ NO

Insurance Information (Please fill out completely)

Name of your **Primary Dental Insurance** _____ Phone (_____) _____ - _____

Address _____ City _____ State ____ Zip _____

Name of Subscriber _____ Relation to Patient _____ Birthdate ____/____/_____

SS#/SIN (required if utilizing Insurance) _____-____-_____ Policy/ID # _____ Group # _____

Name of Employer _____ Work Phone (_____) _____ - _____

Do you have Medical Insurance? YES ☐ NO ☐ If yes, please complete the following:

Name of your **Primary Medical Insurance** _____ Phone (_____) _____ - _____

Address _____ City _____ State ____ Zip _____

Name of Subscriber _____ Relation to Patient _____ Birthdate ____/____/_____

SS#/SIN (required if utilizing Insurance) _____-____-_____ Policy/ID # _____ Group # _____

Name of Employer _____ Work Phone (_____) _____ - _____

~I certify that I have read, understand, and fully accept the policies mentioned above. The above questions have been accurately answered. I understand that my insurance carrier may pay less than the actual bill for services. This signature on file is my authorization for the release of information necessary to process my claim, and that I accept full responsibility for all charges rendered on my behalf or my dependents.

_____
Signature of Patient (Or Parent/Legal Guardian, if minor) Date