

PATIENT INFORMATION

Today's date _____

Name -----

Male Female MI Mr Mrs Ms Dr

I prefer to be addressed as: _____

Birth date ____ / ____ / ____ Age -----

SSN# _____ - _____ - _____

Driver's license # -----

Mailing address-----

Email address-----

Home phone -----

Cell phone-----

Work phone _____ Ext -----

May we call you at work? _____

Employer/school-----

Employer's address -----

How long there? _____ Occupation-----

Where and when are best times to reach you?

WHAT ARE YOUR DENTAL CONCERNS?

- Pain
- Time
- Quality
- Mercury
- Finances
- Understanding
- Appearance
- Other _____
- Trust
- Noise
- Sterilization



Whom may we thank for referring you? _____

**SPOUSE/GUARDIAN INFORMATION
PERSON RESPONSIBLE FOR ACCOUNT**

Name _____

Billing address _____

Home phone _____

Work phone _____ Ext _____

Relationship _____

SSN# _____ - _____ - _____

Employer _____

Driver's license # _____

OTHER DEPENDENTS

	Name	Date of birth
1.	_____	____/____/____
2.	_____	____/____/____
3.	_____	____/____/____
4.	_____	____/____/____

EMERGENCY CONTACT

Name _____

Relationship _____

Home phone _____

Work phone _____

PHYSICIAN INFORMATION

Physician's name _____

Phone number _____

Date of last visit _____

My preferred
pharmacy/location _____

****Please sign to verify the information on this page is correct.****

Signature _____

Date _____

PRIMARY DENTAL INSURANCE

SECONDARY DENTAL INSURANCE

Insurance co. _____

Insurance co. _____

Address _____

Address _____

Phone _____

Phone _____

Group # (plan, local, or policy #) _____

Group # (plan, local, or policy #) _____

Insured's name _____

Insured's name _____

Insured's address _____

Insured's address _____

Relationship _____

Relationship _____

Insured's birth date ____/____/____

Insured's birth date ____/____/____

Insured's SSN# _____ - _____ - _____

Insured's SSN# _____ - _____ - _____

Insured's employer _____

Insured's employer _____

If you have dental insurance, we are happy to help you receive your maximum allowable benefits and are pleased to bill your insurance directly. Some insurance companies select certain services they will not cover. The manner in which usual and customary fees are determined may vary from policy to policy. Any balance owed after insurance payment will be the patients responsibility .

*****PLEASE READ AND SIGN BELOW*****

Office Appointment Policy

In order to meet all our patient's needs we require at least 24 hour notice to change an appointment. There may be a charge of \$50 per hour if proper notice is not given.

By signing below I acknowledge that the information I provided on these forms is correct. My signature also verifies the agreement that I am financially responsible for all charges on my account regardless of insurance benefits and coverage.

Signature _____

Date _____

Name _____ Date _____

Name of Physician or Dr's Office _____ Phone _____

Are you taking any prescription medications, over-the counter drugs or herbal supplements?

Please list all: _____

Are you allergic to or have you reacted adversely to any of the following?

Acrylic/Finger nail polish	Yes	No	Metal	Yes	No
Aspirin	Yes	No	Penicillin	Yes	No
Codeine	Yes	No	Sulfa	Yes	No
Latex	Yes	No	Tetracycline	Yes	No
Local anesthesia	Yes	No	Other:	_____	

Do you have or have you had:

Yes	No	Prosthetic heart valve	Yes	No	Congenital Heart Disease
Yes	No	Heart Transplant	Yes	No	Artificial joint Which Joint/Date of surgery? _____

Do you have or have you had:

Yes	No	Radiation treatment	Where?	_____
Yes	No	Chemotherapy	For?	_____

Are you currently taking or have you ever taken **bisphosphonates**, either orally or by IV? **Yes** **No**
(Examples. Aredia, Zometa, Fosamax, Actonel, Boniva)

Have you ever been treated for:

- | | | |
|--|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Numbness/tingling in body |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Oral Herpes |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pain in Jaw Joints |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Psychiatric Issues |
| <input type="checkbox"/> Arthritis/Rheumatism/Gout | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> Asthma/Breathing problems | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anxiety/Depression/Panic Attack | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Seizures/Epilepsy/Convulsions |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Cancer/Tumor | <input type="checkbox"/> HIV positive/AIDS | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Cold Sores/Oral Herpes | <input type="checkbox"/> Hives or skin rash | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cortisone Treatment | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Surgical shunts, pins, plates |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Drug/alcohol Addiction | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Easily winded | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis/Lung Disease |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Neck or Back pain/Injury | <input type="checkbox"/> Yellow Jaundice/Scarlet Fever |

Do you suffer from any other conditions not listed? _____

Do you: Smoke **Yes** **No** Chew/Dip **Yes** **No** If yes, how much for how long? _____

Women: Pregnant or Nursing **Yes** **No** Taking Contraceptives or Hormones **Yes** **No** Reached menopause **Yes** **No**

I have personally given the above information to the best of my knowledge, understanding that all medications/health information is confidential and necessary for the doctors to evaluate, diagnose and protect my health and well-being. I also understand that any changes/additions to this history are my responsibility to report prior to my next appointment.

Patient Signature Date

Notice of Privacy Practices Acknowledgement (HIPPA)

We keep a record of the health care services we provide you. You may request to see these records and request copies. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so, as noted in our privacy policies. You may see your record or get more information about these privacy policies (HIPPA) by contacting the manager of Dr. Hollar & Dr Low's office/Above & Beyond Dentistry & Implants.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ Date _____
Patient or legally authorized individual signature

_____ Relationship _____
Printed name if signed on behalf of the patient (parent, legal guardian personal representative)

I authorize the following people/person access to my records:

- Spouse: (name) _____
- Significant Other: (name) _____
- Care Taker: (name) _____
- Other: (name) _____
- None

ABOVE & BEYOND DENTISTRY & IMPLANTS

Financial Policy

If you have dental insurance, we are happy to help you receive your maximum allowable benefits. In order to achieve this goal we need your assistance and your understanding of our payment policy.

- **We need you to provide us with updated/current insurance information**

You will be asked to update your personal and insurance information periodically, including providing our office with copies of your insurance card. We are required by law to obtain your signature for permission to release information to your insurance carrier. Please assist us in complying with your insurance requirements.

- **The treatment plan we propose is an estimation based on the information provided by your insurance company.**

Verification of your insurance is not a guarantee of payment. Amounts due by you (the patient/guarantor), are based on what has been quoted to us via fax, phone, or online services, and is not necessarily your entire balance. Your insurance company determines payment, according to the policy you have chosen and the contract your employer has with them when the claim is received. Every effort is made by this office to submit accurate information to your insurance company.

- **Outstanding balances are due immediately regardless of any insurance appeals/discrepancies**

If you do not agree with the way your insurance company has paid your claim, have any questions regarding claim payment, or payment has not been made, please contact your insurance company for explanation. Existing balances on your account must be paid in full prior to receiving additional services even if you are appealing or questioning claims payment. If additional payment is received causing credit on your account a refund will be made to you.

- **Our relationship is with you, not your insurance company**

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. All though we may be have fee negotiations with your insurance company, we must emphasize that as a dental care provider, our relationship is with you, not your insurance company.

- **Payment is due at time of appointment**

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date the services are rendered. Payment for services, including insurance co-payment or self-pay balance amount, is due at the time services are rendered unless payment arrangements have been approved in advance by the Office Manager.

By my signature below I agree to the terms of the Statement of Payment Policy.

Patient or Responsible Party on Account

Date _____