# *ENDODONTIC PARTNERS OF WEST ALABAMA*

## *Dr. Mills, Dr. Graves and Dr. Duque*

*Date:* _____

*Patient legal Name* _____ *Nick name* _____

*Date of Birth* _____ *SS#* _____

*Cell #* _____ *Alterative #* _____

*Mailing address* _____

*Email address* _____

*Marital Status* __ *Minor* __ *Single* __ *Married* __*Divorced* __ *Widowed*

*Do you take pre-medication antibiotics before every dental procedure?*
__ *Yes* __*No*

*Name of antibiotic* _____

*Pharmacy name* _____

*Pharmacy phone #* _____

*Whom may we thank for referring you?* _____

*Who is your family dentist?* _____

*Place of employment* _____

*Employer address* _____

*Employer phone #* _____

*If a minor:*

*Responsible party legal name* _____

*Responsible party date of birth* _____

*Responsible party SS#* _____

*Responsible party Employer* _____

*Address* _____

*Phone #* _____

# *Insurance Information*

*We will be happy to file DENTAL insurance claims for you at no extra charge. The insurance company will also issue a check payable to the dentist. In addition, you must provide our office staff the proper information (dental insurance card, SS# and date of birth of the person you are filing insurance under).* ***The ESTIMATED difference that the insurance does not pay must be paid the day of the office visit.***

## *Primary Dental Insurance Company*

*Insurance Company* _____

*Phone #* _____

*Policy Holder's name* _____

*Relationship to Patient* _____

*Date of Birth* _____ *Social Security #* _____

*Place of Employment* _____

*Contract or I.D. #* _____

*Group #* _____

*Insurance Co. mailing address* _____

## *Secondary Dental Insurance Company*

*Insurance Company* _____

*Phone #* _____

*Policy Holder's name* _____

*Relationship to Patient* _____

*Date of Birth* _____ *Social Security #* _____

*Place of Employment* _____

*Contract or I.D. #* _____

*Group #* _____

*Insurance Co. mailing address* _____

# MEDICAL HISTORY

Name _____ Date of Birth _____

*Have you ever Had (circle yes or no)*

| | | |
|---|---|---|
| Heart problems (heart attack, surgery, valve) | Y | N |
| High blood pressure | Y | N |
| Chest pains (Angina) | Y | N |
| Anemia | Y | N |
| Bleeding problems | Y | N |
| Swelling of hands/feet | Y | N |
| Artificial Joint (hip, knee) | Y | N |
| Blood transfusion. When? _____ | Y | N |
| Tuberculosis (TB) | Y | N |
| Difficulty breathing | Y | N |
| Asthma | Y | N |
| Sinus congestion | Y | N |
| Venereal disease | Y | N |
| Herpes | Y | N |
| Cold sores of fever blisters | Y | N |
| Frequent ulcers in mouth | Y | N |
| Bleeding gums | Y | N |
| Pain in jaw (TMJ) | Y | N |
| AIDS or been exposed | Y | N |
| High risk group for AIDS | Y | N |
| Epilepsy | Y | N |
| Dizzy or Fainting spells | Y | N |
| Seizures | Y | N |
| Psychiatric treatment | Y | N |
| Hepatitis | Y | N |
| Liver disease | Y | N |
| Diabetes | Y | N |

*Ulcers or stomach problems* Y N

*Cancer or Tumor* Y N

*Are you pregnant?* Y N

*Do you take birth control pills?* Y N

*Are you Currently under the care of a doctor?* Y N

*If so for what reasons* _____

*Name of Physician* _____

*Surgery or hospitalization in the past 2 years? Please list them*

_____

*Are you currently taking any prescription medications?* Y N

*Do you have any diseases or conditions not mentioned above?* Y N

*If so please explain* _____

*Are you ALLERGIC to any of these:*

*Aspirin* Y N

*Codeine* Y N

*Darvon* Y N

*Penicillin* Y N

*Latex* Y N

*Novocain* Y N

*Antibiotics not listed, if so* _____

*Other medications* _____

*Have you ever had a reaction to an injection or medication given to you by your dentist?*
Y N *If yes please explain* _____

*To the best of my knowledge the above information is accurate and true. If the patient is a minor, I as the parent/guardian give my permission for any needed dental treatment. I understand that it is my responsibility to inform the dental office of any changes in my medical status, or that of my dependent.*

*Signature* _____

*Date* _____

# *OFFICE PAYMENT POLICY*

*This is a referral practice, and a mutual respect for obligation is essential to permit our business to be conducted on an efficient and friendly basis. Therefore, to avoid misunderstandings concerning payment of accounts, please note that endodontic treatment is usually completed in one visit and must be paid in full. We will be happy to file* ***DENTAL*** *insurance claims for you at no extra charge if the insurance company will issue a check payable to the dentist.* ***In addition, you must provide our office staff with proper information (dental insurance card, social security number, and date of birth of the person you are filing insurance under).*** *The* ***ESTIMATED*** *difference that the insurance does not pay must be paid the day of the office visit.*

*Your insurance is a contract between you as a subscriber, and the insurance company as insurer, involving our office only indirectly. Therefore, any controversy which might arise over our insurance company allowance and your total indebtedness remains your responsibility. Any insurance claims that have not been paid within 60 days of treatment will be billed back to you.*

- ☐ *I have dental insurance; I will pay my copay today.*
- ☐ *I will pay in full today.*
- ☐ *I will charge to: Master Card _____ Visa _____ Discover _____CareCredit _____ Check _____ Other ____*

******$30.00 service charge on any returned checks******

*I hereby assign, transfer, and set over to James V. Mills D.M.D and Andrew E. Graves D.M.D, all rights, titles, and interest to my dental reimbursement benefits under my insurance policy, I authorize the release of any dental information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand I am financially responsible for all charges for my dependents, or myself whether they are covered by insurance. In the unlikely event this account is submitted to collection, I the undersigned agree to pay all collection costs and reasonable attorney fees. Any account over 30 days* ***past due*** *will be assessed as a monthly billing charge equal to 11/2 % of the unpaid balance. (18% annually)*

*Guarantor Signature* _____ *Date* _____

*Witness* _____ *Date* _____

**For the Office of:**

**Endodontic Partners of West Alabama**

## PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ Patient Names: _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

❑ Cell Phone Confirmation
❑ Email Confirmation
❑ Text Message to my Cell Phone
❑ Work Phone Confirmation
❑ Home Phone Confirmation
❑ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

❑ Cell Phone Confirmation
❑ Email Confirmation
❑ Text Message to my Cell Phone
❑ Work Phone Confirmation
❑ Home Phone Confirmation
❑ **Any of the Above**

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In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

_____ _____

Please ***print*** name of Patient | Please ***sign*** Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian | Relationship of Legal Representative / Guardian

**OFFICE USE ONLY**

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❑ It was emergency treatment
❑ I could not communicate with the patient
❑ The patient refused to sign
❑ The patient was unable to sign because
❑ Other (please describe _____

**Signature of Privacy Officer** _____