Patient Information

Patient Name_____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Cell: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Email: _____

Emergency Contact: _____ Tel No.: _____

Health Information

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer _____
- ☐ Diabetes Type I or II
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A B C
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Existing Pregnancy Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Medicine Allergies

MEDICATIONS*

- ☐ _____
- ☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you ever taken antibiotics prior to dental treatment? ☐ Yes ☐ No
  If yes, please give reason and specific medication: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Are you interested in changing anything about your smile? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you interested in any cosmetic procedures? ☐ Yes ☐ No
  If yes, please check all that apply: ☐ Botox ☐ Veneers ☐ Whitening ☐ Orthodontics ☐ Other, please explain:

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Cell: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services regardless of coverage. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I have read and agree to your HIPAA Notice of Privacy Practices effective 7/16/2013. I have read and agree to the office financial policy. If applicable, I hereby authorize my insurance company to assign benefits directly to Shore Smiles Dental Arts, LLC, and/or Dr. Patricia Grantham.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Financial Policy and Assignment of Benefits Agreement
SHORE SMILES DENTAL ARTS, LLC

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so 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 costs.

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 a contract between you, your employer and the insurance company. Our office is not a party to that contract. If payment from your insurance company is not received within 60 days from the date of service, you will be expected to pay the balance in full.

Your **estimated** co-payment for treatment, which is the amount not covered by your insurance, is due at the time service is provided. Your total responsibility may be adjusted after the time of service depending upon the final reconciliation of the insurance benefit payment. Our office accepts, cash, personal checks, Visa, Mastercard, American Express and Discover. In addition, we offer outside financing available through CareCredit.

As a courtesy, we will assist you in processing all your insurance claims. You must direct your insurance company to pay your benefits directly to our office by signing the authorization of the Assignment of Benefits Agreement at the end of this document. In order for our office to file your insurance claim, you must bring a completed dental insurance form or proof of insurance at each appointment.

Our office will accept an assignment of benefits from your insurance company with the provisions listed below. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance 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 office from your insurance company. By having our office process your insurance forms, it is important you understand this does not eliminate your financial obligation to make payment directly to our office for your treatment.
- We require you 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 office.
- We require you to pay the estimated co-payment (which may include a deductible and/or other fees) which is the amount not covered by your insurance company at the time services are provided. 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 30-45 days from the time of billing. If your insurance company has not made payment to our office within 60 days, you will be required to pay the outstanding balance immediately upon billing. You will be responsible for seeking reimbursement from your insurance company. Returned checks and/or any balances over 30 days will be subject to finance charges at the rate of 1.5% per month (18% annually), late fee of $25 and/or and collection fees as incurred.
- Our office does not guarantee your insurance company will pay for treatment you receive from our office. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full balance immediately upon billing.
- Our office will not enter into a dispute with your insurance company over any claim. We will provide necessary documentation your insurance requests to support your claim. We will cooperate fully with the regulations and requests of your insurance company. However, it is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.
- A non-refundable deposit is required for any appointment 1 hour and 30 minutes or longer. The deposit amount shall be the estimated patient co-payment for that particular visit. Any cancellation without 2-business day notice will forfeit that deposit.
- Any appointment cancelled without 48-hour notice will be subject to a $50 cancellation fee.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the most positive experience in dental care. **I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THIS FINANCIAL AND ASSIGNMENT OF BENEFITS AGREEMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE DOCTOR.**

_____	_____	_____
Print Name	Signature Patient/Responsible Party	Date

HIPAA Notice of Privacy Practices
SHORE SMILES DENTAL ARTS, LLC

THIS NOTICE DESCRIBES HOW MEDICAL/DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW CAREFULLY.

This Notice of Privacy Practices describes how may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for other purposed that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical, dental or mental health condition and related health care services.

- **Uses and Disclosures of Protected Health Information.** Your protected health information may be used and disclosed by your physician, dentist, our office staff and others outside our office involved in your care and treatment for the purpose of providing healthcare services, to pay your healthcare bills to support the operation of the dentist/physician's practice, and any other use required by law.
- **Treatment.** We will use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party (such as family members, etc.) We will also disclose to a family member, spouse, adult children any information necessary for your overall dental care. By signing this document you give permission to share your dental health information with any family member, friend or other persons to the extent necessary to assist with your healthcare and/or payment for your healthcare. For example, we may disclose your PHI, as necessary, to a home health agency that provides care to you; we may need to share information with a specialist or physician to whom you have been referred to enable additional diagnosis and treatment.
- **Payment.** Your PHI will be used as needed to obtain payment for your health/dental care services, including from your family members or friends. For example, obtaining payment from your insurance carrier which will require your PHI be disclosed as a condition for payment.
- **Healthcare Operations.** We may use or disclose, as needed, your PHI in order to support the business activities of the office. These activities include, but are not limited to, quality assessment activities, employee review, activities, training of medical/dental students, licensing, and conducting or arranging for other business activities. For example, a sign-in sheet at the registration desk or to remind you of an appointment via mail or by phone.

We may use or disclose your PHI in the following situations without your authorization: These situations include: Public Health issues, as required by Law, Communicable Diseases, Health Oversight Abuse or Neglect, Food and Drug Administration requirements, Legal Proceeding, Law Enforcement, Coroners, Funeral Directors, organ donation services, research, criminal activity, military activity and national security and/or Workers' Compensation. Under the Law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Your Rights. Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.

You have the right to request restriction of your PHI. This means you may ask us not to use or disclose any part of PHI for the purpose of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and must state the specific restriction requested and to whom you want the restriction to apply. Your physician/dentist is not required to agree to a restriction that you may request. If dentist believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communication by us by an alternative means or at an alternate location. You have the right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this Notice alternatively, i.e. electronically.

You have the right to have your physician/dentist amend your PHI. If we deny your request, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. We reserve the right to change the terms of this Notice and will inform you of any changes by posting in office and by mail. You then have the right to object or withdraw as provided in this Notice.

Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by our office. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This Notice was published on **July 17, 2013.**

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 PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number 609-281-5335.

AGREED AND ACCEPTED:

_____	_____
Print Name	SS#
_____	_____
Signature Patient/Responsible Party	Relationship to Patient