Dental Health Associates

NEW PATIENT INFORMATION

Whom may we thank for referring you or how did you hear about us? _____

[ ] Male [ ] Female

Name: _____ I prefer to be called:_____

[ ] Single [ ] Married [ ] Child [ ] Other

Birth Date:____/____/_____ Age:_____ Social Security #:_____

Address: _____ Apt/Unit #:_____ City:_____ State:____ Zip:_____

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

Employer:_____

Email Address:_____

DENTAL INSURANCE INFORMATION

Primary Insurance: _____

Policyholder's Name: _____ Birth Date:____/____/_____ Relation:_____

Policyholder's Social Security #: _____ Policy Holder's Employer:_____

Group #: _____ ID #: _____

EMERGENCY CONTACT INFORMATION

Name:_____ Relation:_____

Phone #: _____

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice at any time and that I may contact Dental Health Associates at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed: _____ Date: _____

CONSENT FOR TREATMENT AND BILLING

Patient Treatment Consent:

The information on these pages is true to the best of my knowledge. The undersigned hereby authorizes the doctor to take X-rays, study models, photographs, or other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental health needs. I authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicted in connection with the patient, and further authorize and consent that doctor choose and employ such assistance as deemed fit. I understand I have the right to decline x-rays and/or treatment at any time.

Patient Notice:

Dental Health Associates will gladly submit all claims to your insurance company and all benefits will be assigned to the Doctor unless you request other in writing. We do require all copays to be paid at the time of visit.

Dental Health Associates accepts cash, checks, Master Card, Visa, Discover, Care Credit.

Patient Consent:

I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, regardless of insurance coverage. I understand that some services may not be covered by my insurance contract. In the event a given procedure is not covered for any reason (i.e. frequency limitations, benefit maximum reached) payment for these services is my responsibility.

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

I agree to pay my balance in full upon receipt of an invoice unless financial arrangements with the accounts manager have been made. I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 10% annually. I further understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I grant my permission to you and your assignee, to telephone me at home, on my mobile, or at my work to discuss matters related to this form and my account.

I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing.

Signed: _____ Date: _____