Patient Information

Patient Name: _____ Date: _____
Last First MI

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

Social Security #: _____ Birth Date: _____

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

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: _____
Street Apartment #

_____
City State Zip Code

Email Address: _____ (This will be used for confirming appointments only.)

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

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

☐ AIDS
☐ Allergies _____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Mitral Valve Prolapse
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date: _____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ _____
☐
_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, 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? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office 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): _____ Ext: _____ Best time to call: _____

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

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 in cash at the time services are performed.

If you have dental insurance, we will make a good faith estimate of your benefits and defer billing you for that amount up to 60 days. We will file the appropriate claim forms with your insurance company, provided you provide us with your personal information including social security number (or insurance identification number) and date of birth. We will also assist you in understanding your dental plan benefits.

If your insurer denies coverage, or if we otherwise do not receive payment within 60 days from the date of services are rendered, the amount will then become due and payable by you.

Fees for treatment are due at the time treatment is rendered after deduction of your good faith estimate of insurance benefits as described above.

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.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

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 grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

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 and Cancellation Policy Agreement

The goal of **Ivy Dentistry LLC** is to provide exceptional customer service and excellent dental care with both a professional and personal touch. We want to make certain our financial policies are clear and understood by you.

Insurance Coverage

If you have dental insurance, we will make a good faith estimate of your benefits and defer billing you for that amount **up to** 60 days. We will file the appropriate claim forms with your insurance company, provided that you provide us with your personal information including social security number (or insurance Identification Number) and date of birth. We will also assist you in understanding your dental plan benefits.

If your insurer denies coverage, or if we otherwise do not receive payment within 60 days from the date services are rendered, the amount will then become due and payable by you. Please remember that your coverage is a contract between you and your insurer and/or your employer and your insurer. Although we will make every effort to help you obtain your benefits, we *cannot guarantee* your insurance will pay.

Patient Payments

Fees for treatment are due at the time treatment is rendered after deduction of your good faith estimate of insurance benefits as described above.

Payment Options: Cash, Check, Credit Card (Visa, Mastercard, Discover and American Express), Debit Cards and Capital One Healthcare Finance.

Patient Responsibility

I acknowledge my responsibility for payment of services rendered by Ivy Dentistry LLC in accordance with Ivy Dentistry LLC fees and terms. I understand my responsibility is not modified by whether any third party (insurance) pays for all, part or none of the charges. If the balance on your account is not paid within 30 days of statement, your account will become delinquent and will be forwarded to a third party collection agency. If this becomes necessary additional fees may be added to cover handling charges.

Assignment and Release

I authorize payment to be made directly to the dentist by my insurance company and I accept financial responsibility for all service not covered by my insurance and I authorize release of any medical care information requested by my insurance carrier. This agreement becomes effective the date the patient begins their first visit with Ivy Dentistry LLC.

Cancellation Policy

At Ivy Dentistry LLC, we recognize that in today's busy world, adhering to a schedule is important in order to maximize time and meet the demands of daily life. With this in mind, we have developed a cancellation policy that is fair to both our patients and our practice.

We are committed to seeing our patients on time and respecting their time. Late cancellations (less than 48 hours notice), failed appointments, and late arrivals are disruptive to our schedule and other patients.

In order to maintain our schedule we request 48 hours notice for cancellations or rescheduling of appointments. In the instance of a late cancellation (less than 48 hours notice) or a failed appointment there will be a $40.00 charge.

Please make sure to provide our office with the best and most current contact information for you so that we may call to confirm/remind you of your appointment time.

I acknowledge that I have received a copy of the financial and cancellation policies of Ivy Dentistry LLC.

_____ _____

Signature of Patient Date

Ivy Dentistry LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____