PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice. Please fill out the following information.

Persons involved in Care: By signing this form, you will consent to our use of your dental care records to the following persons, including those involved in your care or payment for that care. Please list the person(s) you would like involved in your care or payment for that care.

_____ _____

_____ _____

_____ _____

Print Name_____ Signature _____Date_____

Financial Policy:

A 5% courtesy discount: For established patients at time of service – payments made by cash, check, HSA, or qualifying debit cards (Visa, Mastercard, or Discover).

Credit Card: We accept Visa, Mastercard, and Discover credit cards (no 5% discount).

Established good credit: We will bill you. Payment in full is expected within 21 days of statement date.

Treatment plans exceeding $1500:

1. If you have dental insurance – Pre-treatment estimate must be completed prior to commencement of treatment.
2. If you DO NOT have dental insurance OR if insurance will not provide benefits for the planned procedure(s) – Credit card or debit card must be on file for automatic monthly deduction prior to start of treatment. We accept Care Credit cards; ask us about details.

**Default of payment: Any balances not paid in full within 60 days from date of transaction will result in a 1.5% monthly finance charge. If delinquent payments continue, the account may be turned over to a collection agency and patient(s) will be dismissed.

Financial Responsibility:

Children under 18: The parent/legal guardian who brings in the child is responsible for payment.

Divorce/Separation: Please notify office staff immediately so accounts can be separated for future billings.
**Accounts cannot be separated until the outstanding balance is paid.

Patients over age 18: If a dependent, we will bill the parents. If someone is under legal guardianship it is necessary for the guardian to sign forms. Patients are responsible for all charges incurred.

**We feel it is important to keep you informed of your treatment costs. At any time you may request a treatment plan estimate. Please keep in mind certain circumstances may alter treatment or fees.

Insurance Policy

We are happy to file the necessary forms to help you receive the full benefits of your coverage(s); however we make no guarantee of any estimated coverage or payment. Because insurance is an agreement between you and your insurance company, all patients are responsible for all charges.
**Secondary insurance does not coordinate benefits on pre-estimates.

Broken Appointment Policy

Our patients are very important to us. When there is a broken appointment another patient is denied the opportunity for treatment. We therefore require a minimum 24 hour or one full working day notification to cancel appointments (whichever is greater). Failure to do so will result in:

1st time: Warning and $50 charge
2nd time: Patient Dismissal

I have read and agree to the previously listed policy:

Signed:_____ Date:_____

If under age 18, Guarantor Signature:_____ Date:_____

Patient Medical History Form

Patient's Full Name:_____

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

Address:_____

City:_____ Zip:_____ Birthdate:_____

Gender: Male / Female Occupation:_____

Reason for dental visit today:_____

Are you currently under the care of a doctor? Yes / No If yes, why?_____

Medical Doctor's Name:_____ City:_____

Phone:_____ Date of last medical visit:_____ Reason:_____

Medications:_____

_____

☐ Medication list attached

Please **CHECK** (Yes/No) if **YOU** have or ever had any of the following:

YES / NO

☐ ☐ High or Low Blood Pressure
☐ ☐ Heart Disease/Defects/Surgery/Stents
☐ ☐ Heart Attack
☐ ☐ Stroke

☐ ☐ Cancer
☐ ☐ Radiation Therapy When:_____
☐ ☐ Chemotherapy When:_____
☐ ☐ Bone-loss Drugs (eg. Fosamax, Zometa)
☐ ☐ History of Osteoporosis

☐ ☐ Lung Disease/Shortness of Breath
☐ ☐ Asthma

☐ ☐ Liver Disease
☐ ☐ Abnormal Bleeding
☐ ☐ Taking Blood Thinners
☐ ☐ HIV/AIDS
☐ ☐ Diabetes
☐ ☐ Organ Transplant
☐ ☐ Kidney Disease/On Dialysis

☐ ☐ Intellectual Disability
☐ ☐ Alzheimer's/Dementia
☐ ☐ Epilepsy/Seizures

YES / NO

☐ ☐ Artificial Joint
Location of Joint:_____
When was it placed:_____
☐ ☐ Take Antibiotics Before Dental Work
Reason:_____

☐ ☐ Allergies to Drugs/Medications
Which ones:_____
☐ ☐ Other Allergies:_____
_____

☐ ☐ Tobacco Use / Packs Per Day?_____
☐ ☐ Alcohol Use
☐ ☐ Recreational Drug Use
☐ ☐ Cocaine Use
Females:
☐ ☐ Are You Pregnant? Due Date:_____
☐ ☐ Taking Birth Control?

**I certify that the information provided on this form is correct to the best of my knowledge.

_____
Patient / Parent or Guardian's Signature

_____
For The Office

DE PERE SMILES s.c.

PATIENT INFORMATION FORM

NAME (Last, First, MI)_____PREFERRED NAME_____

HOME ADDRESS_____
(street) (city) (state) (zip)

HOME PHONE_____WORK PHONE_____CELL NO._____

EMAIL ADDRESS_____

SS#_____-_____-_____ DATE OF BIRTH_____/_____/_____ SEX: M / F STATUS: S/ M/ D/ W

EMPLOYER NAME_____

EMERGENCY CONTACT & PHONE_____

RELATIONSHIP TO PATIENT_____

PLEASE CHECK WHICHEVER APPLY:

☐ PRIMARY DENTAL INSURANCE ONLY; SUBSCRIBER NAME_____
☐ PRIMARY DENTAL INSURANCE & SECONDARY DENTAL INSURANCE
☐ NO DENTAL INSURANCE AT THIS TIME

DE PERE SMILES s.c.

I AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO MY DENTAL CLAIMS. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DE PERE SMILES, S.C. OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT THE ABOVE INFORMATION IS GIVEN FOR THE PURPOSE OF OBTAINING CREDIT, AND I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND ACCURATE, AS OF THE DATE OF THIS APPLICATION. I GIVE MY PERSONAL GUARTANTEE FOR ALL CHARGES INCURED.

SIGNATURE_____DATE_____

RESPONSIBLE (**if under 18 years of age**)
PARTY

_____
(Name) (Address) (SS#)