PATIENT INFORMATION

NAME_____ □ MARRIED □ SINGLE □ MINOR □ MALE □FEMALE
Last First M

SOCIAL SECURITY #_____ EMAIL_____

ADDRESS_____
STREET APT# CITY STATE ZIP

DOB_____/_____/_____ TELEPHONE_____
HOME WORK MOBILE

NAME OF EMPLOYER_____ ADDRESS_____

IF FULL TIME STUDENT, SCHOOL NAME_____ GRADE_____

PERSON RESPONSIBLE FOR ACCOUNT- PLEASE CHECK ONE: □ PATIENT □ GUARDIAN □ SPOUSE □ FATHER □ MOTHER

MINOR CHILD- MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS- COMPLETE PRIMARY INSURED

INSURANCE INFORMATION

PRIMARY INSURED/ RESPONSIBLE PARTY

NAME_____ EMAIL_____
Last First M

TELEPHONE_____
HOME WORK MOBILE

ADDRESS_____
STREET APT# CITY STATE ZIP

NAME OF EMPLOYER_____ INS CO._____

SOCIAL SECURITY #_____ SUBSCRIBER ID_____ DOB_____/_____/_____

GROUP #_____ RELATIONSHIP TO PATIENT_____

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME_____

ADDRESS_____

City/State/ZIP_____

TELEPHONE #_____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic. Photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

X_____
Patient or Responsible Party

_____
Date State Driver's License #

Has any member of your family ever been treated in our office?
□Yes □No

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

MEDICAL HISTORY UPDATE

Are you under a physician's care now? □YES □ NO
If yes, why? _____

Have you ever been hospitalized or had a major operation? □YES □NO
If yes, why? _____

Have you ever had a serious head or neck injury? □YES □NO
If yes, discuss _____

Are you taking any medications, pills, or drugs? □YES □NO
List: _____

Are you on a special diet? □YES □ NO

Are you allergic to any medication or substances? □YES □NO
Circle: ASPRIN PENICILLIN CODEINE NOVOCAIN ACRYLIC METAL LATEX RUBBER OTHER_____

Women, please check: Pregnant/trying to get pregnant, _____Nursing _____Taking oral contraceptives

Patient's Name: _____ Date of Birth: _____

MEDICAL HISTORY

DO YOU HAVE ANY OF THE FOLLOWING? Please check if appropriate.

□ Heart Murmur	□ Stroke	□ Hemophilia	□ Tumors/ Growths	□ Hepatitis A, B, C
□Mitral Valve Prolapse	□ Pacemaker	□ Leukemia	□ Emphysema	□ Kidney Disease
□ Rheumatic Fever	□ High B. P.	□ Blood Transfusion	□ Cancer	□ Venereal Disease
□ Heart Surgery	□ Low B. P.	□ Lung Disease	□ Radiation	□ HIV Positive
□ Artificial Heart Valve	□ Blood Disease	□ Breathing Problems	□ Diabetes	□ Tuberculosis
□ Artificial Joint	□ Anemia	□ Asthma	□ Psychiatric Care	
□ Heart Trouble	□ Glaucoma	□ Epilepsy/Seizure	□ Liver Disease	

Have you ever had any other serious illness not checked above? □YES □NO If yes, explain _____

Do you wish to talk to the dentist privately about any problems? □YES □NO

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X_____ Date_____
Patient's Signature (Parent / Guardian)

DENTAL HISTORY

Primary reason for dental appointment: Exam_____ Emergency _____ Consultation _____

Do you have a specific dental problem? □YES □NO Describe _____

Do you have dental examinations on a regular basis? □YES □NO Last Visit? _____

Are your teeth sensitive to: □Cold □Hot □Sweet □Biting □Touch

How would you describe your present dental health? □Good □Fair □Poor

Do you think you have active decay? □YES □NO

Do you think you have gum disease? □YES □NO

Do your gums bleed? □YES □NO

Do you have a concern for bad breath? □YES □NO

Have you ever been taught to control dental disease? □YES □NO

How often do you brush? _____

How often do you floss? _____

Have you ever had: □Gum Surgery □Braces □TMJ (Jaw Joint) Therapy

Do you ever have: □clicking □popping □discomfort in the jaw point? Do you clench/grind your teeth? □YES □NO

Do you smoke or chew tobacco products? □YES □NO How much/long? _____

Do you have any sores or growths in your mouth? □YES □NO If so, where? _____

Are you pleased with the appearance of your teeth? □YES □NO

Please describe any changes you would like to take in the appearance of your teeth: _____

_____

North Forest Family Dental

Dr. Betzy Lara-Perdue

Welcome Letter

Dear New Patient,

We would like to take this opportunity to welcome you as a patient and to thank you for choosing our office! It is our goal to provide superior dental care to you and your family. We wish to make your visits to our office as informative and comfortable as possible. We would also like to take this opportunity to inform you of our office policies.

We pride ourselves in trying to see all patients on time, however there are times when true dental emergencies cause our schedules to run behind. Because we realize your time is valuable, all efforts will be made to inform you if this happens during your scheduled appointment.

Please be so kind as to inform us 24 hours prior to your appointment if you will be unable to keep your scheduled time. Cancellations with less than 24 hours notice (or not showing up) will result in a broken appointment fee of $50.00 an hour. Appointments scheduled for longer than 1 ½ hours will require a deposit ($50 an hour) that will be credited to your account.

In most circumstances, patients 18 years and older will need to have a set of x-rays taken once a year. Younger patients will require x-rays twice a year. Some insurance companies only cover x-rays once a year making you responsible for the cost of the second set of x-rays that year.

Treatment cannot be rendered to anyone under the age of 18 without a parent or legal guardian present in the office.

If you are currently in braces, you will be required to have your orthodontic wires removed so that we can take x-rays and properly clean your teeth. As a courtesy to our patients, our office may be able to remove the wires with prior authorization from your orthodontist. If we are not able to remove the wires you will be asked to visit your orthodontist prior to coming here for your appointment. You will be required to return, **that same day,** to have your orthodontist put the wires back on.

If you are insured with Medicaid: Medicaid has changed over to a managed care type plan, therefore, you must choose **Dr. Betzy A Lara-Perdue** as your dental provider. We currently accept: MCNA Dental and DentaQuest. If we are unable to verify that the patient is assigned to our office, you will be asked to reschedule your appointment and call Medicaid to have them make the change effective as soon as possible to avoid delay in treatment. Please bring your insurance card with you to each appointment showing Dr. Betzy A Lara-Perdue as your dental provider. If you miss more than one scheduled appointment, we are required to notify your insurance plan that you are not keeping your appointments. As a result, you may lose your benefits. We do not want this to happen, so please keep all scheduled appointments.

If you have a change in your insurance coverage, please let us know when scheduling your appointment. This will allow us time to verify benefits and inform you of any changes in your coverage and provide you with an estimate of your out of pocket costs. However, you are responsible for paying for services rendered whether or not your insurance company pays its estimated portion.

Children are a very large part of our practice and community. We kindly ask that they respect our facilities. Please help us keep the noise volume low so that it does not disturb our staff from performing their responsibilities effectively. Friendly reminders will be given, if needed. We will not be responsible for any injury your child may sustain as a result of being unruly in our office. Please do not allow your children to jump on our furniture, climb on our counter tops, bang on the windows, or pull on our wall fixtures.

Please do not bring children with you to your personal appointment unless they can sit quietly in the waiting room without supervision. Our staff will not be able to watch your children, so please make prior arrangements.

If you have any questions, please do not hesitate to contact us. We look forward to helping you and your family have a lifetime of healthy smiles.

_____ _____

Signature: Patient, Parent, Legal Guardian Date

FINANCIAL POLICY

Our mission is to deliver the finest most cost effective Dental Care available today. Following diagnosis, the doctor will advise you on a plan for treatment.

Payment for today's visit and your future visits are due at the time of treatment. In an effort to make dentistry more affordable for you, we participate in two basic types of dental benefit programs.

- **Indemnity Dental Insurance** allows for your reimbursement of a percentage of the fees for treatment services. Your insurance policy is a contract between you and your insurance company. When we accept your insurance company's assignment, it does not absolve you from full responsibility for the charges in full for the treatment rendered. The estimate provided by our office is considered as a guideline until the final insurance payment, if any, is received and the patient's account has been paid in full. We make no guarantee of the insurance payment as estimated. The agreed upon payment plan for the patient's estimated portion must be kept current or the assignment will be canceled and the full amount will become due and payable. Claims are submitted promptly after treatment is rendered, and if not paid by the patient's insurance company by the 60th day after treatment is rendered, the total outstanding account balance will be billed directly to the patient. Our team prides itself on helping our patients maximize their benefits. We are always available to answer questions you may have regarding your treatment. **Predetermination-** Another way of determining your exact liability is to have our dental office file a Predetermination of dental benefits. Predetermination may take up to six weeks, thereby delaying the start of your dental treatment.

- **PPO (Preferred Provider Organization)** type programs are preferred providers or referral programs which entitle the participant to reduced fees according to their plan fee schedules and usually a discount on services not covered by the plan. These plans generally have a percentage of the fees that are paid by the patient at the time treatment is rendered. Some plans require a claim for submission once series have been provided.

There will be an additional charge for any duplication of patient's records that may be requested.

Payment Options

- Cash- includes money orders and personal checks.
- Credit Card- Visa, Master Card, American Express, Discover and Debit Cards.
- Dental Fee Plan- We offer a separate line of credit to cover your entire family's health care needs.
    - A credit line may be established and approval usually takes less than 10 minutes.
    - No payment is needed today to start treatment.
    - Dental Fee Plan is 90 days same as cash on treatments greater than $300.00
    - There is no annual or membership fee.
    - Monthly payments are as low as 3% of the outstanding balance.

It is your responsibility to pay for services at the time you receive them, regardless of any dental plan or insurance benefits you may have. We will provide monthly statements on accounts that have a balance. Unpaid account balances greater than 61 days will be charged a finance charge of 1.75% per month (21%) APR.

By signing below, I understand that I am financially responsible for all charges whether or not my insurance covers them. I hereby assign my insurance benefits to be paid to North Forest Family Dental Care. I also authorize the doctor to release to my insurance carrier(s), any information required to process any claim(s).

_____ _____

Patient Name (Please Print) Date of Birth

_____ _____

Signature of Patient (Parent/Legal Guardian) Date

HIPAA PRIVACY
ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I, _____ [Please print full legal name here] (the "Patient" or "Patient's legal representative"), have been presented with the Notice of Privacy Policy (the "Policy") of **North Forest Family Dental Care**, and have been offered a copy of such policy to keep for my records.

_____ [Please initial here] I hereby acknowledge that I have read the Policy and understand its terms and conditions.

_____ [Please initial here] I hereby refuse to acknowledge receipt of the Policy and refuse to read or acknowledge any of the terms and conditions of the Policy. I understand that even though I may refuse to sign this acknowledgement, Provider may still provide treatment.

_____ _____

Signature (Patient or Legal Guardian) Date