New Patient Information 2021

Welcome to our office!

PERSONAL INFORMATION

Name: ____ Birthday: _____/_____/________ Sex: _____M _____F

Address: ____ Driver's License /ID #: __________________ State: _________

City/State: _______________________ Zip: ______________ Social Security #: ____________________________________

Phone: ___________________ Work: __________________ Employer: ____

Marital Status: Single/ Married/ Divorced/ Widowed/ Separated Address: ____

Email: ____ Employer Phone: ______________________________________

Reason for Today's Visit: ______________________________

Emergency Contact Name: ______________________________ Is this accident related? □ Yes □ No

Phone: ________________ Relation: ____________________ Are you covered under an employer or union? □ Yes □ No

PRIMARY DENTAL INSURANCE INFORMATION

Policy Holder: ______________________________________

Group/Company Name: ________________________________

Insurance Member ID #: ___________________________

MEDICAL INSURANCE INFORMATION

Policy Holder: ______________________________________

Group/Company Name: ________________________________

Insurance Member ID #: ___________________________

PRIMARY PHYSICIAN

Physician Name: _____________________________________ Phone: ____________________

Date of Last Visit: ____________________________________ Chief Complaint: ______________________________________

All medical history must be listed here to accommodate your visit correctly.

MEDICAL HISTORY

Have you been tested for sleep apnea? □ Yes □ No

Have you been previously diagnosed with TMJ or TMJD? □ Yes □ No

Have you received previous treatment for TMJ or TMJD? □ Yes □ No

Are you allergic to Penicillin, Aspirin, or any other drug? □ Yes □ No Other: __________________________________

Have you ever had a reaction to Novocain or Anesthesia? □ Yes □ No Date: ___________________________________

CHILDREN ONLY

Has ever had pink eye? □ Yes □ No

History of Head Lice? □ Yes □ No Currently have Head Lice? □ Yes □ No Last Date of Treatment: ___________________

Are vaccinations up to date? □ Yes □ No

WOMEN ONLY

For women only: Are you pregnant? □ Yes □ No Nursing? □ Yes □ No Had exposure to HPV? □ Yes □ No

MEDICATIONS

Does the patient have any drug allergies? If Yes, list all.

____

____

Please list **ALL** medications you are currently taking:

____

____

____

*****Please continue on the backside of this sheet*****

Have you ever used a bisphosphonate medication? Fosamax, Actonel, Atelvia, Didronel, Boniva. □ Yes □ No

Past or Present History of (Circle all that apply): **□ None Apply**

Accidental Injury to teeth/mouth	Blisters on Lips, Tongue, Mouth
Burning of Tongue	Chew on One Side of Mouth
Clench/Grind Teeth	Dental Fractures
Dry Mouth	Growths or Lesions in Mouth
Gums Swollen, Tender, Bleeding	Head, Neck, Jaw Pain
Lip or Cheek Biting	Loose Teeth or Broken Fillings
Mouth Breathing	Orthodontic Treatment
Nitrous Oxide	Periodontal Treatment
Sensitivity to Hot/Cold	Cold Sores

When was your last dental visit? ________________________ How often do you floss? ______________________________

How often do you brush your teeth? _______________________ Are you in pain? ____________________________________

Is the damaged tooth a capped or previously restored tooth? ____

Have you had any of the following? (Circle all that Apply) or Check **□ None Apply**

AIDS/HIV	Anaphylaxis
ADD, ADHD	Autism
Anemia	Diabetes, Swelling of Feet/Ankles
Arthritis, Rheumatism, Cortisone Treatments	Artificial Heart Valves/Joints/ Mitral Valve Prolapse
Asthma, Shortness of Breath, Respiratory Disease	Atopic (Allergy Prone)
Anxiety, Depression	Heart Surgery, Pacemaker
Artificial Joints, Surgical Implant	Heart Attack
Back Problems, Spine Bifida	Blood Disease
Cancer/ Chemotherapy/ Radiation Treatment	Chemical Dependency, Tobacco Habit
Circulatory Problems, Blood Transfusion	Cortisone Treatments
Cholesterol	Epilepsy/Seizures
Cough, Coughing Blood	Food Allergies
Fainting	Headaches/Migraines
Glaucoma/Cataracts	Heart Murmur/Problems
Hemophilia/ Abnormal Bleeding	Herpes
Psychiatric Care/Bipolar	High Blood Pressure
Shingles, Skin Rash, Scarlet Fever	Stroke
Hepatitis (A B C)	Liver Disease/ Cirrhosis
Kidney Disease. Malfunction	Thyroid Disease, Malfunction, Tonsillitis
Material Allergies: Latex, Wool, Metal, Chemicals	Tuberculosis
Ulcer/Colitis	Venereal Disease

Are there any other health conditions you may have that are not listed? ____

HOW DID YOU HEAR ABOUT US?

Facebook	Medicaid/Medicare	Referred By:
Website/Internet Search	Friend/Family/Doctor	________________________________

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information. This information will be kept confidential.

I am aware that a copy of my insurance identification card will be made available and a copy kept in my records. I am responsible for updating this information if and when there are changes.

______________________________ ______________________________

Signature Date

HIPPA Privacy Policy

I understand that I have certain rights to privacy regarding my protected 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 heath information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (i.e. my insurance company)
- The day to day healthcare operation 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 from time to time and that I may contact you 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 theses 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.

Print Patient Name: ________________________________ Relation to Patient: ______________________________

Signature: ____ Date: ________________________

Staff Member: ____

HIPAA Right of Access Form for Family Member/Friend

I, ________________________________, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

***** We Will Not Disclose Any Information to Anyone Unless Listed on This Form*****

Name: ________________________________ Relationship: ______________________

Address: ______________________________ Phone #: __________________________

Name: ________________________________ Relationship: ______________________

Address: ______________________________ Phone #: __________________________

Health information to be disclosed upon the request of the person name above. (**Check either A or B**):

☐ A. Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions)

☐ B. Disclose my health record, as above, **BUT DO NOT** disclose the following (check as appropriate):

- ☐ Mental Health Records
- ☐ Communicable Diseases (including HIV & AIDS)
- ☐ Alcohol/ Drug Abuse Treatment
- ☐ Other: ____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

☐ An electronic record or access through an online portal

☐ Hard copy

☐ All past, present, and future periods

Date or event: ____________________________________unless I revoke it. (Note: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

Printed Patient Name: ____ Date: ________________

Patient Signature: ____

Staff Member: ____

*****Please continue on the backside of this sheet*****

Office Policies

We, the staff of Vela-Loftin Dental Center, thank you for choosing us as your dental/health provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is not only to inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time, you have any questions or concerns regarding our fees, policies, or responsibilities please feel free to contact **Tiffany** at **361-664-8352**.

We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients. Please understand that payment for services is an important part of the provider-patient relationship. In order to keep our costs reasonable, we require payment at the time of service unless our staff has approved payment arrangements in advance. We make payment as convenient as possible by accepting (Cash, Money Order, MasterCard, Visa, Care Credit and in-state checks). A $35.00 service fee will be charged for all returned checks. You may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. We have found that insurance companies may try to limit or dictate the services, or level of service a provider can offer to their patients. This leaves the provider of service and the patient with a direct relationship and the opportunity to make the final decision as to which treatments are most beneficial for the patient. We have found that insurance carriers will request needless and redundant information from a provider of service much more frequently than a patient will. If you have insurance, we will bill your carrier and provide you with a copy of your claim for billing purposes. Any requests for additional forms from your insurance company will gladly be accommodated. This includes records, reports, tests, etc. We will provide you with the additional information to submit to your insurance company so there can be no doubt in your mind that we are complying with their request. Please retain the original copy for your files. If we are not contracted with your carrier, we will not negotiate reduced fees with your carrier.

Missed Appointments

We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. Repeated missed appointments (3) without notification may cause you to be set on a "walk-in only" our practice so that we can provide care to other patients.

Medical Records

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines, and exceptions to ensure compliance to patient rights. We require a prior signed authorization of medical release by the patient. Please indict all authorized person(s) you are authorizing. Authorized person(s) must present valid identification upon request.

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

I have read and understand the above financial policy. I agree to assign insurance benefits to whenever applicable. I also agree, in addition to the amount owed, I will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

____ ____________________

Patient/Guardian Signature Date

Insurance Policy

Loftin Dental Center processes your claims as a courtesy. We will only process primary and secondary in network claims at this time. Assignment of benefits is selected to sure proper payment is made to our facility. If your plan does not allow the assignment of benefits option, you are solely responsible for any payments issued to you by your insurance provider for services rendered at our practice. Loftin Dental Center will allow 30 days from your check clearance date to submit payment to us. If no payment is made, you will be charged private pay fees. If your insurance company pays directly to the member, Loftin Dental Center will ask for full payment at time of treatment.

There is no guarantee of payment until your claim is reviewed by the insurance claims department. Loftin Dental Center will appeal denials at no charge. If an approval cannot be obtained, you will be solely responsible for any remaining balance for all services rendered.

This policy also extends to inactive insurance status at time of treatment. If you are due to terminate of your policy or employment, your insurance company may retro date all services at any time to reflect your termination date. This balance will be solely your responsibility.

Signing below states that you understand this policy and take full responsibility for finances.

____ ___________________________

Patient/Guardian Signature Date

Care Credit

PAYMENT PLAN OPTION

Here at Vela-Loftin Dental Center, our mission is to provide the best and most comprehensive dental care available. An important part of that mission is making the cost of optimal care as easy and manageable as possible. To help you with this investment, we have partnered up with Care Credit to provide you with a way to make monthly payments that fit your budget.

What is Care Credit?

Care Credit offers patients payment plans that allow you to pay overtime with conveniently low minimum monthly payments. With Care Credit, you enjoy these benefits:

- **Flexible financing option**
- **No Annual Fees or Prepayment Penalties**
- **Quick and Easy Application**
- **Receive a Credit Decision almost Immediately**
- **Start your Recommended Treatment Immediately**

□ Yes! I would like to apply for Care Credit.

□ No, I am not interested at this time.