Stephanie J Allen, DMD
www.riverridgedentist.com
info@riverridgedentist.com

434 Patrol Road, Suite 200
Jeffersonville, IN 47130
(812) 850-2129

Welcome to Allen Family Dental

Patient Name:_____

Title:_____ (Mr/Ms/Mrs/etc) **Family Status** : ○Married ○Single ○Child ○Other

Date of Birth: _____ **SSN:** _____ **Last dental visit?**_____

Email Address:_____

Home Phone:_____ **Cell Phone:**_____

Address:_____**City**_____**State**_____

Zip_____

Responsible Party (If patient is under 18 or if someone other than the patient is responsible)**:**

Name: _____ Date of Birth_____

Home/Cell Phone: _____

Address:_____City_____State_____

Zip_____

Responsible Party/Patient Signature _____Date_____

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

In an emergency who should be notified? Please enter name and phone number below:

_____

_____

Consent for Services and Financial Policy

As a condition of 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. Financial responsibility on the part of each patient must be determined before treatment.

I understand that any fee for treatment planned dental care can only be extended for a period of six months from the date of the patient examination.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from the insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

Insurance Authorization: ▢ By checking this box,

- I authorize my insurance company to pay the dentist all insurance benefits rendered.
- I authorize the use of this electronic signature on all insurance submissions
- I authorize the dentist to release all information necessary to secure the payment of benefits
- I understand that I am financially responsible for all charges whether or not paid by insurance

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or unless other financial arrangements have been made. I further agree that the charges for service shall be as billed unless objected to, by me, in writing, within the time payment is due. 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 to discuss this statement or my treatment.

I understand if I do not show for a scheduled appointment that <u>I will be responsible for a $25 fee.</u>

I understand that a 24-hour notice is required when cancelling or moving my appointments or <u>I will be responsible for a $25 fee.</u>

Responsible Party/Patient Signature _____Date_____

Consent for Internet Communications

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information:

· We may have to disclose your health information to another health care provider or a hospital if it is necessary for our office to refer you to them for consultation or treatment.

· We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your service.

· We may need to use your personal information to remind you of your appointments.

I understand that all email or text communications in which I engage may be forwarded to other providers for the purposes of providing treatment to me. This may include but not be limited to sending your x-rays and/or minimal personal information to other providers via email or text. We strive to keep all patient information secure but unfortunately there is no assurance of confidentiality of information when communicating this way.

I have read and understand this policy and agree to the terms.

Responsible Party/Patient Signature _____Date_____

HIPAA Acknowledgement

Your Privacy is important to us at Allen Family Dental.

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of Allen Family Dental. I hereby authorize as indicated by my signature below, Allen Family Dental, to use and disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

▢ You may contact me at my home telephone number
▢ You may contact me on my mobile phone number
▢ You may send me an email
▢Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians: (example: John Doe (212) 555-1212)

_____

_____

_____

Responsible Party/Patient 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
▢Communication barriers prohibited obtaining acknowledgement
▢An emergency situation prevented us from obtaining the acknowledgement
▢Other:_____

MEDICAL HEALTH HISTORY

Name of your primary medical physician:_____ Phone number_____

▢ Are you required to premedicate before any dental treatment?

Do you have, or have you had any of the following? (Please check any that apply)

▢Blood Problems (Anemia)
▢Blood transfusion
▢Heart problems (CHF, MI, arrhythmia, angina,etc)
▢Heart murmur, mitral valve prolapse, heart defect
▢Heart Pacemaker
▢Stroke_____
▢Bone or joint problems
▢Artificial joint or valves_____
▢High or low blood pressure (circle one)
▢Tuberculosis or other lung problems
▢Kidney disease
▢Hepatitis, jaundice or other liver disease
▢Diabetes TYPE 1 or TYPE 2 (circle type)
▢Epilepsy or Neurological disorders
▢Thyroid problems
▢Arthritis
▢Herpes or cold sores
▢AIDS or HIV positive
▢Cancer/Tumor
▢Abnormal bleeding after any surgery (heavy bleeder)
▢Hay-fever or sinus trouble
▢Allergies
▢Asthma
▢Other_____

Are you allergic to, or have you reacted adversely to any of the following?

▢Latex
▢Penicillin or other antibiotics
▢Local anesthetics
▢Codeine or other narcotics
▢Sulfa drugs
▢Barbiturates, sedatives, or sleeping pills
▢Aspirin
▢Other:_____

Please List All Current Medications:_____

_____

_____

_____

Do you smoke,vape or use tobacco? ▢yes ▢no

Women:
Are you pregnant? YES or NO

▢Taking hormones or oral contraceptives

Have you ever or are you currently receiving any oral or IV bisphosphonates? ▢no▢yes:

_____

Describe any current medical treatment, impeding surgery or other treatment that may possibly affect your dental treatment?

_____

_____

I acknowledge that I have reviewed all questions/alerts on this form and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any further changes. This will serve as my electronic signature.

Responsible Party/Patient Signature _____**Date**_____
Dentist Signature _____**Date**_____