PATIENT INFORMATION

NAME: _____ ☐ SINGLE ☐ MARRIED ☐ MALE ☐ SEPARATED/DIVORCED ☐ FEMALE
LAST FIRST M.I.

NICKNAME OR PREFERRED NAME: _____

ADDRESS: _____
STREET APT# CITY STATE ZIP

BIRTHDATE: _____ EMAIL: _____
MONTH DAY YEAR

HOME PHONE: _____ CELL PHONE: _____
OK TO CALL? ☐ YES ☐ NO OK TO CALL? ☐ YES ☐ NO

WORK PHONE: _____ OTHER: _____
OK TO CALL? ☐ YES ☐ NO OK TO CALL? ☐ YES ☐ NO

WOULD YOU LIKE US TO CONFIRM YOUR APPOINTMENTS? ☐ YES ☐ NO ☐ EMAIL ☐ CALL CELL ☐ CALL HOME ☐ CALL WORK
(IF YES, PLEASE INDICATE PREFERENCE)

PLACE OF EMPLOYMENT: _____ SS#: _____

SPOUSE'S NAME: _____

DENTAL INSURANCE

DO YOU HAVE DENTAL INSURANCE? ☐ YES ☐ NO
IF YES, PLEASE GIVE OUR BUSINESS OFFICE YOUR INSURANCE CARD WITH THIS FORM. WE WILL TAKE A PHOTOCOPY AND RETURN IT TO YOU.

EMERGENCY CONTACT (OUTSIDE OF IMMEDIATE FAMILY):

NAME: _____ TELEPHONE: _____
FIRST LAST ☐ HOME ☐ CELL

ADDRESS: _____
STREET CITY STATE ZIP

HAS ANY MEMBER OF YOUR FAMILY BEEN TREATED IN OUR OFFICE? ☐ YES ☐ NO

IF YES, NAME: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

WOULD YOU LIKE TO USE NITROUS OXYGEN (RELAXING GAS) DURING YOUR APPOINTMENT? (AN EXTRA FEE APPLIES) ☐ YES ☐ NO

IS THERE ANYTHING WE CAN DO TO MAKE YOUR VISIT MORE ENJOYABLE? _____

_____

AUTHORIZATION

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO CLASSIC DENTISTRY OF THE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT I AM RESPONSIBLE FOR THE COSTS OF ALL DENTAL TREATMENT RECEIVED BY ME, REGARDLESS OF THE BENEFITS PAID BY MY INSURANCE CARRIER. I HEREBY AUTHORIZE CLASSIC DENTISTRY TO ADMINISTER SUCH MEDICATIONS AND PERFORM SUCH DIAGNOSTIC, PHOTOGRAPHIC, AND THERAPEUTIC PROCEDURES AS MAY BE NECESSARY FOR PROPER DENTAL CARE. I FURTHER UNDERSTAND THAT ALL DENTAL RADIOGRAPHS ARE THE PROPERTY OF CLASSIC DENTISTRY, AND THE FEES CHARGED FOR SUCH RADIOGRAPHS ARE PROFESSIONAL PAYMENT FOR EXPERT OPINION IN THE DIAGNOSIS AND PREVENTIVE MAINTENANCE OF 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 HISTORIES AND OTHER INFORMATION ABOUT MY DENTAL TREATMENT TO THIRD PARTY PAYERS AND/OR OTHER HEALTH PROFESSIONALS.

PATIENT SIGNATURE: _____ DATE: _____

PATIENT NAME: _____ DATE: _____

PRIMARY REASON FOR THIS DENTAL APPOINTMENT: ☐ EXAMINATION ☐ EMERGENCY ☐ CONSULTATION

☐ YES ☐ NO DO YOU HAVE A SPECIFIC DENTAL PROBLEM? DESCRIBE:_____

☐ YES ☐ NO DO YOU HAVE REGULAR DENTAL EXAMINATIONS? DATE OF LAST EXAM: _____

DATE OF LAST FULL MOUTH X-RAYS (16 SMALL OR ONE LARGE PANORAMIC FILM):_____

☐ YES ☐ NO DO YOU BRUSH YOUR TEETH ON A ROUTINE BASIS?

☐ YES ☐ NO DO YOU FLOSS YOUR TEETH ON A ROUTINE BASIS?

☐ YES ☐ NO DO YOUR GUMS EVER BLEED? DESCRIBE: _____

☐ YES ☐ NO DO YOU LIKE YOUR SMILE? WHY OR WHY NOT? _____

☐ YES ☐ NO DOES FOOD CATCH BETWEEN YOUR TEETH?

☐ YES ☐ NO DO YOU HAVE ANY LOOSE TEETH?

☐ YES ☐ NO ANY SORES OR GROWTHS IN YOUR MOUTH? DESCRIBE: _____

☐ YES ☐ NO DO YOU EVER HAVE CLICKING, POPPING, OR DISCOMFORT IN THE JAW JOINT?

☐ YES ☐ NO DO YOU BRUX OR GRIND?

☐ YES ☐ NO DO YOU SMOKE OR CHEW?

MEDICAL HISTORY

PHYSICIAN'S NAME: _____PHONE: _____ IF UNDER CARE, DESCRIBE: _____

☐ YES ☐ NO HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR OTHER MEDICATIONS CONTAINING BISPHOSPHONATES?

☐ YES ☐ NO HAVE YOU BEEN HOSPITALIZED/HAD A MAJOR OPERATION? DESCRIBE: _____

☐ YES ☐ NO HAVE YOU EVER HAD A SERIOUS INJURY TO YOUR HEAD OR NECK? DESCRIBE: _____

☐ YES ☐ NO ARE YOU TAKING ANY MEDICATIONS, PILLS, OR DRUGS? PLEASE LIST:

_____

☐ YES ☐ NO HAVE YOU EVER TAKEN FEN-PHEN?

☐ YES ☐ NO HAVE YOU HAD ANY PROBLEMS WITH CLINDAMYCIN OR C-DIFF?

☐ YES ☐ NO ARE YOU ALLERGIC TO: ☐ ASPIRIN ☐ PENICILLIN ☐ CODEINE ☐ ACRYLIC ☐ METAL ☐ LATEX RUBBER ☐ SULFA DRUGS ☐ LOCAL ANESTHETICS ☐ OTHER: _____

WOMEN--ARE YOU: ☐ PREGNANT/TRYING ☐ NURSING ☐ TAKING ORAL CONTRACEPTIVES-DESCRIBE: _____

HAVE YOU EVER BEEN TOLD BY YOUR PHYSICIAN THAT YOU NEED PREMEDICATION? ☐ YES ☐ NO

ARE YOU CURRENTLY ON BLOOD THINNERS? ☐ YES ☐ NO NAME OF MEDICATION: _____

PLEASE PLACE A CHECKMARK NEXT TO ANY OF THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST:

☐ AIDS/HIV POSITIVE	☐ CORTISONE MEDICINE	☐ HEMOPHILIA	☐ RECENT WEIGHT LOSS
☐ ALZHEIMER'S DISEASE	☐ DIABETES	☐ HEPATITIS A	☐ RENAL DIALYSIS
☐ ANAPHYLAXIS	☐ DRUG/ALCOHOL ADDICTION	☐ HEPATITIS B OR C	☐ RHEUMATIC FEVER
☐ ANEMIA	☐ EASILY WINDED	☐ HERPES	☐ RHEUMATISM
☐ ANGINA	☐ EMPHYSEMA	☐ HIGH BLOOD PRESSURE	☐ SCARLET FEVER
☐ ARTHRITIS/GOUT	☐ EPILEPSY OR SEIZURES	☐ HIGH CHOLESTEROL	☐ SHINGLES
☐ ARTIFICIAL HEART VALVE	☐ EXCESSIVE BLEEDING	☐ HIVES OR RASH	☐ SICKLE CELL DISEASE
☐ ARTIFICIAL JOINT	☐ EXCESSIVE THIRST	☐ HYPOGLYCEMIA	☐ SINUS TROUBLE
☐ ASTHMA	☐ FAINTING SPELLS/DIZZINESS	☐ IRREGULAR HEARTBEAT	☐ SPINA BIFIDA
☐ BLOOD DISEASE	☐ FREQUENT COUGH	☐ KIDNEY PROBLEMS	☐ STOMACH/INTESTINAL DISEASE
☐ BLOOD TRANSFUSION	☐ FREQUENT DIARRHEA	☐ LEUKEMIA	☐ STROKE
☐ BREATHING PROBLEMS	☐ FREQUENT HEADACHES	☐ LIVER DISEASE	☐ SWELLING OF LIMBS
☐ BRUISE EASILY	☐ GENITAL HERPES	☐ LOW BLOOD PRESSURE	☐ TATTOOS
☐ CANCER	☐ GLAUCOMA	☐ LUNG DISEASE	☐ THYROID DISEASE
☐ CHEMOTHERAPY	☐ HAY FEVER	☐ MITRAL VALVE PROLAPSE	☐ TONSILLITIS
☐ CHEST PAINS	☐ HEART ATTACK/FAILURE	☐ OSTEOPOROSIS	☐ TUBERCULOSIS
☐ COLD SORES/FEVER BLISTERS	☐ HEART MURMUR	☐ PAIN IN JAW JOINTS	☐ TUMORS OR GROWTHS
☐ CONGENITAL HEART DISORDER	☐ HEART PACEMAKER	☐ PARATHYROID DISEASE	☐ ULCERS
☐ CONVULSIONS	☐ HEART TROUBLE/DISEASE	☐ PSYCHIATRIC CARE	☐ VENEREAL DISEASE
		☐ RADIATION TREATMENTS	☐ YELLOW JAUNDICE

ANY SERIOUS CONDITION NOT LISTED ABOVE? _____

TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS FORM HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION COULD COMPROMISE MY (OR THE PATIENT'S) HEALTH. IT IS MY RESPONSIBILITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES IN MEDICAL STATUS.

SIGNATURE OF PATIENT OR GUARDIAN: _____ DATE: _____

ACKNOWLEDGMENT OF FINANCIAL AND INSURANCE POLICIES

The following are Classic Dentistry's financial and insurance policies. Please read over this information carefully and call our Business Office with any questions or concerns. Most misunderstandings may be avoided through clear communication prior to the beginning of treatment. In order to demonstrate you have read, understand, and agree to these policies, please sign the back of this form and return it when you come into the office for your first visit.

Financial Policy

We realize the financial aspect of dental care is an important consideration for our patients. We offer several options from which our patients may choose:

1. Payment is due when services are rendered. We accept cash, check, Visa, Mastercard, Discover, and Care Credit.
2. For patients with dental insurance, we will accept assignment of benefits. However, an ESTIMATED co-pay is due when services are rendered. Please note: **we are not a participating provider for any managed insurance plan**. Contracted dentists are obligated to charge fees dictated by the insurance company which often require deep discounts. In our experience, participating in these plans requires a significant increase in fees charged to non-plan patients in order to off-set these discounts. Our philosophy is simple: we do not treat our patients differently based on what insurance plan they have and we therefore do not charge our patients different fees for the same procedure.
3. Patients needing to pay their out-of-pocket costs over three-months or up to 24-months may apply to one of the companies with which we have partnered to offer financing options. Out-of-pocket costs must exceed $250 in order to qualify for one of these plans. Generally speaking, no-interest financing is available for three- or six-month financing. Longer-term financing is also available at competitive rates. The application process is private and very simple.
4. Occasionally, a patient may end up with a balance on their account. Balances owed directly to the office must be paid within 30 days of receipt of statement. A 1.5% financing fee will be applied to accounts with outstanding balances over 30 days. An additional $20.00 late fee will be applied to any account failing to make a payment within a billing cycle. Therefore, should you need more than 30 days to pay your balance, it is in your best interest to arrange interest-free financing through one of the companies with which we have partnered.

Outstanding dental bills may interfere with the doctor-patient relationship, and this relationship is the most important thing to us. It is for this reason we encourage our patients needing financing to utilize outside sources. It is our desire to keep our relationship unencumbered by financial conflicts.

By working together, we believe we can offer treatment that optimizes your dental health without creating a financial hardship for you and your family. Please feel free to talk with our Business Office Staff about any financial concerns you may have.

Appointment Cancellation and Failed Appointment Policy

Patient accounts for cancellations made on the same day as the appointment will be charged $25. Appointments missed, but not cancelled, will result in a $50.00 charge to the account.

Insurance Policy

Dental insurance is a wonderful benefit that can help defray the cost of necessary dental work. We realize our patients need our help to obtain the benefits to which they are entitled and we are committed to providing this service. However, the potential for misunderstandings is increased when insurance coverage is involved because each plan is unique and coverages vary.

Please read over the following information carefully so conflicts regarding your insurance coverage may be avoided.

<u>Treatment Recommendations</u>

We recommend treatment based on what you need to restore (or maintain) your optimal health. These services may or may not be covered by your policy. As a relationship-based practice, we strive to help you fully understand why certain procedures are necessary prior to beginning treatment. Ultimately, you decide what treatment to accept. We hope you will base your acceptance of treatment on what you need and NOT on what your insurance company will cover.

Filing Claims/Assignment of Benefits

As a service to our patients, we are happy to file your dental insurance claims for you. Should your plan allow, we will accept assignment of benefits, provided you are willing to pay your estimated co-payment at each visit and you agree to pay any unreimbursed expenses within 30 days of notification.

Blue Cross/Blue Shield of Nebraska and Delta Dental: These companies do not allow assignment of benefits to non-participating providers. Therefore, patients covered under these policies are asked to pay in full at the time services are rendered. Your benefit check will be payable and mailed to you directly from your insurance carrier.

Reimbursement

Your policy may base reimbursement on a fixed fee schedule which is arbitrarily set by the insurance plan. Even those companies that use "geographical averages" to determine reimbursement are usually using fee data that is several years old. Our fees are determined by the costs associated with providing each service. Although there are many plans that "allow" our entire fee, there are also plans that do not.

We charge our usual and customary fees to all patients, regardless of insurance coverage. To accept as payment-in-full the amount "allowed" or "covered" by insurance would constitute insurance fraud. It would also be grossly unfair to our patients without insurance coverage. For these reasons, we do NOT adjust our fees for any insurance plan.

Should you need a general idea of benefits payable prior to accepting treatment, we will be happy to file a pre-treatment estimate for you upon request. However, these estimates do not guarantee payment, and in order to avoid misunderstandings, you must be prepared to pay for all services rendered, regardless of insurance coverage.

Non-Covered Services

Conflicts arise when patients confuse the role of insurance and the role of the dentist. As your dental care provider, we are obligated to recommend treatment based on the findings of your oral examination and other diagnostic services.

There are occasions when an insurance company will refuse benefits because they have determined the treatment to be "medically unnecessary." Keep in mind that your insurance carrier has not examined you and is therefore in no position to reasonably determine whether or not a treatment was "medically necessary." Do not rely on this judgement alone. If you are in doubt, we encourage you to seek a second opinion from a practitioner who can physically examine you.

Additionally, there are certain procedures that fall in the cracks between dental and medical coverage. TMJ appliances and therapies, dental implants, and snore guards are a few examples. Some procedures will not be covered simply because they are excluded from your plan.

The bottom line is: you, the patient, need to fully understand why the treatment you are receiving is necessary. You need to be committed to receiving treatment regardless of insurance coverage. If you are unsure about a recommended treatment, **ask questions**, **express your doubt**, and **communicate with us**. If you are still unsure, **seek a second opinion**. Your insurance company is NOT your doctor and should never be relied upon to dictate your healthcare.

A Final Note

We recognize the costs associated with some dental procedures can place a financial burden on our patients. We are committed to helping you receive all insurance benefits to which you are entitled. To that end, we will file claims, write narratives, submit X-rays, and send pre-treatment estimates. Ultimately, though, our role is limited. Your insurance policy is a contract between you and your insurance carrier. We are not a party to that contract, and are therefore unable to influence your benefit determination. We ask only that you be understanding of our limitations and realistic about your coverage.

I have read the above information and agree to abide by the policies as set forth.

PATIENT NAME: _____

RESPONSIBLE PARTY (if different than patient)**:** _____

SIGNATURE: _____ **DATE:** _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Date:_____

To: Classic Dentistry, P.C.
12123 Pacific Street
Omaha, NE 68154

I hereby authorize CLASSIC DENTISTRY,P.C. to disclose my Protected Health Information to:

For the purpose(s) of:

This authorization is in effect until rescinded. I understand I may rescind my authorization at any time, provided such is provided to CLASSIC DENTISTRY, P.C. in writing.

I also understand that CLASSIC DENTISTRY, P.C. will rely on their professional judgment to determine the minimum necessary disclosure for the purpose(s) stated above.

NAME: _____

ADDRESS: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

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
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

Employee Signature: _____