ADVANCED DENTISTRY OF ARLINGTON

Today's Date:_____

Patient Information

ALL INFORMATION ON THIS FORM MUST BE COMPLETED

Name: _____
First Middle Initial Last Preferred Name

Address: _____
Number and Street Apt No:

_____
City State Zip Code

Date of Birth: _____ **Social Security Number:** _____

Phone: Home _____ **Email:** _____
Work _____ **Would you like to sign up for e-reminders? ____Y ____ N**
Mobile_____ **If yes, which method? ____ Text ____ Email**

Gender: ____ Male ____Female

Emergency Contact: _____
Name Phone Relationship

Marital Status (Please Circle): CHILD SINGLE MARRIED DIVORCED WIDOWED

Insurance Information

Primary Dental Carrier
Insurance Co: _____ Subscriber's Name:_____
SSN/ID NO: _____ DOB: _____ Relationship to Patient:_____
Insurance Co. Phone Number: _____ Employer: _____

Secondary Dental Carrier
Insurance Co: _____ Subscriber's Name:_____
SSN/ID NO: _____ DOB: _____ Relationship to Patient:_____
Insurance Co. Phone Number: _____ Employer: _____

Medical Carrier
Insurance Co: _____ Subscriber's Name:_____
SSN/ID NO: _____ DOB: _____ Relationship to Patient:_____
Insurance Co. Phone Number: _____ Employer: _____

Insurance Authorization

I hereby authorize release of information necessary to process my dental benefit claims and for payment otherwise payable to me to be made directly to Advanced Dentistry of Arlington. I understand that I am responsible for my portion of the approved fee as determined by my plan, and that payment is due at the time services are rendered.

_____ _____
Patient Signature Date

Other Information

How did you hear about our office?_____
Reason for today's visit? _____

MEDICAL HISTORY AND INFORMATION

Conditions

Y	N		Y	N	
☐	☐	ADHD	☐	☐	Hepatitis A B C (Please Specify)
☐	☐	Anemia	☐	☐	Hormone Deficiency
☐	☐	Angina	☐	☐	High Blood Pressure
☐	☐	Arthritis	☐	☐	High Cholesterol
☐	☐	Artificial Joint(s)	☐	☐	Immunosuppression
☐	☐	Asthma	☐	☐	Kidney Disease
☐	☐	Autism	☐	☐	Liver Disease
☐	☐	Blood Transfusion	☐	☐	Osteoporosis
☐	☐	Blood Disorder	☐	☐	Psychiatric Problems
☐	☐	Cancer	☐	☐	Rheumatic Fever
☐	☐	Diabetes	☐	☐	Seizures
☐	☐	Drug/Alcohol Abuse	☐	☐	STD/Venereal Disease
☐	☐	Epilepsy/Fainting	☐	☐	Shingles/Chicken Pox
☐	☐	Fever Blister	☐	☐	Sinus Problems
☐	☐	Headaches/Migraines	☐	☐	Speech/Hearing Impairment
☐	☐	Gastrointestinal Problems	☐	☐	Stroke
☐	☐	Glaucoma	☐	☐	Thyroid Problems
☐	☐	HIV/AIDS	☐	☐	Tuberculosis
☐	☐	Heart Murmur			
☐	☐	Heart Disease			

Others:_____

Allergies

Y	N	
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Iodine
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Sulfa
☐	☐	Tetracycline

Others: _____

☐ ☐ Do you use tobacco products?

For Women

☐ ☐ Are you taking birth control pills?
☐ ☐ Are you pregnant?
☐ ☐ If yes, how many weeks? _____
☐ ☐ Are you nursing?
☐ ☐ Are you undergoing hormone therapy?

Please list any medications you are currently taking: _____

_____

Treatment Authorization

I authorize the Advanced Dentistry of Arlington dental team to perform dental services that I may need and consented to during diagnosis and treatment, including the use of local anesthesia and other medication. I certify that the medical information provided on this page is current and accurate to the best of my knowledge.

_____ _____

Patient Signature Date

Acknowledge of Receipt of Notice of Privacy Practices

I hereby acknowledge that a copy of this practice's Notice of Privacy has been made available to me. I have been given the opportunity to ask questions I may have regarding this Notice.

_____ _____

Patient Signature Date

Authorization to Release Health Information

____ I **DO NOT** authorize the practice to release my health information to anyone except for my insurance carrier
____ I authorize the practice to release my health information to the following parties in addition to my insurance carrier:

_____

Name Relationship Phone Number

_____ _____

Patient Signature Date

Office Policies

At Advanced Dentistry of Arlington, our mission is to provide the highest level of care with equal attention to the comfort and convenience of our patients. The following policies are designed to make this possible.

Financial Agreement

An ***estimate*** of the cost of your recommended treatment plan will be provided at the end of your initial appointment

For easy and affordable care, Advanced Dentistry of Arlington participates with several options:

- PPO Dental Plans
- Dental Discount Plans
- Affordable Care Plans
- Fee for Service/Self-Pay

We accept cash and all major credit cards as methods of payment. Personal check are **NOT** accepted.

Insurance

If you have dental insurance, please note that we are only able to provide an estimate of benefits based on the information provided to our office by you and/or your dental plan. These estimates are not a guarantee that services will be covered. Limitations or exclusions that are not disclosed to our office by your dental carrier may exist in your plan.

If you have multiple dental insurance plans, our office will bill a maximum of two dental insurances for you. Your estimated patient responsibility will be calculated and copay will be collected based on your reported primary insurance benefits only. Once payment is received from your primary insurance, we will submit the claim to your secondary insurance on your behalf and will have your secondary insurance reimburse you directly.

Dental insurance is a contract between the patient and the insurance carrier. Our office will accept assignment of benefits from insurance; however, ultimately, the entire bill remains your responsibility.

In the event that your dental plan does not cover your treatment, is canceled and/or terminated, or eligibility and benefits cannot be verified before your appointment, you are responsible for the full cost of the treatment performed. If and when payment is received from your insurance, you will be notified of any credit or balance due.

All patients are responsible for the full payment of any balance due within ninety (90) days of the date of service.

Failure to pay for treatment on time may result in collection procedures. If collection procedures are required, the patient is responsible for collection costs.

Appointments

Our office hours are:	Monday - Friday	7 AM – 5 PM
	Saturday	8 AM – 3 PM

Confirming Appointments

As a courtesy, our office will send appointment reminders by phone calls, text message, and e-mail. If you would like to opt of the reminder service, please inform our staff and we will update your account to remove up to two of the

communication methods. We reserve the right to keep one communication method to confirm appointments.

Keeping Appointments

Your appointment is a block of time that is especially reserved for your dental care. **Please arrive 10 minutes before your scheduled appointment time** so you have time to find parking and review appointment information.

A late arrival jeopardizes the time available for your visit and our ability to be on time. Patients arriving 10 minutes late or more to an appointment have have to reschedule the appointment. Patients arriving 10 minutes late or more may also be subject to a late fee. Patients who arrive late to or miss three appointments will be dismissed from the office.

Patients who miss an appointment will incur a late fee. Patients who miss three appointments will be dismissed.

For the consideration of your doctors and fellow patients, we require at least 48 hours advance notice to change an appoint. Failure to provide the required 48-hour notice will incur a late fees as follows:

$25 For ALL Dentist Appointments Less Than 1 hour
$50 For ALL Dentist Appointments More Than 1 hour

By signing below, I acknowledge that I understand and agree to the above mentioned office policies.

_____

Patient/Parent/Guardian (Print)

_____ _____

Patient/Parent/Guardian Signature Date

Our dental team is committed to delivering excellent dental care to all our patients. We are glad that you chose our team to care for you.

Welcome to Advanced Dentistry of Arlington!

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 , and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

PATIENT RIGHTS Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail(e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, You may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.