

Patient Information

How did you hear about Allcare? (Select all that apply)

Insurance Referral Saw Building Word of Mouth Direct Mail Newspaper Yellow Pages Radio TV/Cable Internet other

Please Print: Circle One: Dr/Mr./Mrs./Ms/Miss

Last: _____ First: _____ Middle: _____ Jr/Sr: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Employer: _____

Email Address: _____ May we contact you by Email? (Circle) **Yes/No**

Emergency Contact: _____ Phone: _____

Patient Social Security Number: ____ - ____ - ____ Patient Date of Birth: ____/____/____

Responsible Party (If patient is under 18 years old)

Please Print: Circle One: Dr/Mr/Mrs/Ms/Miss

Last: _____ First: _____ Middle: _____ Jr/Sr: _____

Street _____ City _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Employer: _____

Insurance Information

Do you have dental insurance? (Circle) **Yes / No**

Do you have secondary dental insurance? (Circle) **Yes / No**

Primary Insurance		Secondary Insurance	
Subscriber Name		Subscriber Name	
Subscriber ID #		Subscriber ID #	
Subscriber SSN		Subscriber SSN	
Date of Birth		Date of Birth	
Relationship to Subscriber	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Relationship to Subscriber	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Employer Name		Employer Name	
Employer Phone		Employer Phone	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
Insurance Phone #		Insurance Phone #	

Please Present Insurance Card to Receptionist

Do you expect a lapse or termination of your dental insurance within the next 6 months? **Yes / No**

If yes, please explain and provide date of lapse or termination _____ **Date:** _____

Is there anyone that you would allow Allcare to discuss your treatment, appointments, or your financial obligations with? **Yes / No**

If yes, please request a HIPAA form from your Patient Care Manager. You must complete this form before we can discuss your care with anyone.

Health Information – CONFIDENTIAL

Patient Name: _____ DOB: _____

Date of last Dental Visit? _____ Date of last X-Ray _____

Reason for today's visit? _____

Name of Physician: _____ Office Phone Number: _____ Date of Last Physical: _____

Do you take any "blood thinners" such as Asprin, Coumadin, Plavix, etc?

Yes	No
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List any medications you are taking including non-prescription drugs:	1. _____	2. _____	3. _____	4. _____
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Do you have a history of:	Y	N		Y	N		Y	N
Rheumatic Fever			H.I.V. Positive			Bleeding Gums		
Stroke			Excessive Bleeding			Bad taste or odor in your mouth		
Heart Murmur			Any artificial joint replacements			Chew on only one side of your mouth		
Heart Trouble			Epilepsy			Pain in your jaw or near your ears		
Anemia			Ulcers or stomach problems			Popping or clicking in jaws or TMJ		
High Blood Pressure			Hepatitis			Treated/diagnosed with TMJ disorder		
Low Blood Pressure			Lung Disease			Sinus problems		
Heart Abnormalities since birth			Breathing Problems			Any difficult tooth extractions in the past		
Pace Maker/Open Heart Surgery			Asthma			Trouble from previous dental care		
Diabetes			Tuberculosis			Growths or sore spots in mouth		
Liver Disease			Other Illnesses (explain below*)			Ever had Novocain/other local anesthetic		
Fainting or Dizziness			Any surgery or radiation treatment for a tumor, cancer or other condition?			Ever had Nitrous Oxide (laughing gas)		
Venereal Disease			Presently under care of physician			Ever had General Anesthesia		
Arthritis			Are you taking any bisphosphonates such as Fosamax, Actenol, etc?			Allergic reaction to Novocain, local or general anesthetics		
Kidney Disease			Unhealed injuries or inflamed areas in or around your mouth			Any part of the mouth sensitive to pressures or irritants (hot, cold or sweets)		
* Other Illnesses: _____								

WOMEN NOTE	Y	N		Y	N
Is there a possibility of pregnancy?			Are you nursing?		
Estimated due date			Are you taking birth control pills?		
<i>NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult with your physician / gynecologist for assistance regarding additional methods of birth control.</i>					

Have you ever had an adverse/allergic reaction to any medications?	Yes	No		
List any medications you are allergic to:	1. _____	2. _____	3. _____	4. _____

I certify that I have read and understand the questions above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff responsible for any errors that I have made in the completion of this form.

Patient/Guardian Signature _____ Date _____

IMPORTANT - Please read each section below thoroughly. Initial each section in the spaces provided on the left indicating that you have read and understood that section.

_____ **PAYMENT AGREEMENT-** I understand and agree that health, dental and accident insurance policies are an arrangement between an insurance carrier and me. I understand that Allcare will prepare or assist me in preparing any necessary reports and forms to assist me in collecting payment from my insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand and agree that Allcare, as a courtesy to me, will not impose any interest charges to any balance I may incur for a period of thirty days after the charges are incurred. This courtesy will not impose any interest charges to any balance I may incur for a period of thirty days after the charges are incurred, to afford my insurance carrier, if any, that amount of time to make payment. It is understood that any balances outstanding for more than thirty days will be charged interest at the rate of 1.33 percent per month or the maximum rate permitted by applicable law, and I agree to pay said charges. In the event my account balance is referred to an agency or attorneys for collection purposes, I agree to pay reasonable attorney fees and any expenses or costs relating to the collection proceeding, including court costs. In the event that the patient is a minor, I am the parent and/or guardian of said patient and agree that I am responsible for all services rendered to the patient herein. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. (See Interrupted Services Policy below)

_____ **REFUND POLICY –** I understand that, should I request a refund from Allcare, this request should be made to the Manager of the Allcare facility where I am a current patient. The Manager will forward a Refund Request to a Supervisor for final approval. During this process, I understand that my account will be reviewed and any fees for professional services rendered, including interrupted services fees if applicable, will be immediately due and payable. I understand the refund will be administered in the same manner in which I made payment to Allcare. Further, I understand that the refund process can take up to fifteen days to finalize and up to 30 days for a third party lender, if applicable to me, to reflect the refund on my account.

_____ **INTERRUPTED SERVICES POLICY-** I understand and agree that I may be held financially responsible for a portion of the work performed by Allcare if I decide not to return to Allcare for final insertion of prosthetic work. (Does not include Immediate denture packages or Immediate partial packages)

_____ **UNSCHEDULED TREATMENT POLICY-** In the event that I pre pay for treatment but fail to schedule an appointment for that same treatment, I acknowledge that Allcare shall have the right to charge me a reasonable administrative fee, as published on our website www.allcare.com, for any follow-up phone calls made or follow-up letters sent to me by Allcare in its effort to schedule completion of my treatment plan.

_____ **MISSED APPOINTMENT POLICY-** In the event that I miss an appointment or fail to inform Allcare that I will miss an appointment within 24 hours of the scheduled appointment, I acknowledge that Allcare shall have the right to charge to my account a reasonable administrative fee, as published on our website www.allcare.com

_____ **USUAL AND CUSTOMARY POLICY-** You may have been given a courtesy discount for special circumstances. (e.g., including but not limited to senior discounts, etc...) These discounts are based upon your completing treatment. In the event that you decide to discontinue treatment prior to completion of your accepted treatment, the fees charged and any refund given will be based upon Allcare's usual and customary charge for the services rendered and not based on the discounted rate.

_____ **AUTHORIZATION OF PAYMENT OF BENEFITS-** I hereby authorize payment directly to Allcare Dental & Dentures. I agree that a photocopy of this authorization is as valid as the original.

Please indicate coupon that will be used at your first visit.

COUPON: Media Source _____ Discount % _____

I acknowledge that I must mention and show any coupon during my first visit to Allcare in order to receive the discount. Patient must list the coupon or advertisement above for proof of discount and then patient must initial in the space provided as well as sign the disclosure at the end of this section. *One coupon per patient, may not be combined with other offers.* Please note that, subject to applicable law, coupon discounts may vary when combined with insurance.

CHARGECARD AUTHORIZATION- By initialing this section and signing hereunder, I hereby authorize Allcare Dental & Dentures to bill my charge card account should any balances for services remain outstanding for more than sixty (60) days. If the account information given expires or is otherwise discontinued, I agree to give Allcare information as to an alternate charge account which may be used. My account is as follows:

() VISA () MasterCard () Discover () Other (specify) _____
Account Number _____ Expires _____
Signature _____ Date _____

APPOINTMENT REMINDERS- We may use or disclose your health information to provide you with appointment reminders, such as voicemail messages, postcards, or letters.

DENTURE PACKAGES- (this section applies only to patients receiving Immediate Denture or Immediate Partial packages)
I understand that the denture work being provided to me was priced as a complete package and that in the event that I fail to return to Allcare to receive my Permanent Denture within the latter of: (a) twelve (12) months from the date I received my immediate denture; or (b) eight (8) months from the last date that I received care from Allcare with respect to my denture treatment plan, I will not be entitled to any refund or credit to my account. However, in the event that I inform Allcare in writing of my decision not to accept my Permanent Denture prior to the earlier of Allcare manufacturing the Permanent Denture or twelve (12) months from the date I received my immediate/temporary denture, I will be eligible for a \$200 refund for the Permanent Denture.

ACKNOWLEDGEMENT SUMMARY OF NOTICE OF PRIVACY PRACTICES-

Allcare is required by federal law to maintain the privacy of your PHI (Protected Health Information) and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI. By signing this form, you acknowledge receipt of Allcare's Notice of Privacy Practice ("NPP"). Among other things Allcare's NPP provides:

- (a) Notice that Allcare may be required by State Law, under the Privacy Rule, to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.
- (b) Allcare is required to abide by the terms of its NPP.
- (c) Allcare reserves the right to change the terms of its NPP and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- (d) Allcare will distribute any revised Privacy Notice to you prior to implementation.
- (e) Allcare will not retaliate against you for filing a complaint
- (f) Allcare will have a copy of its NPP available at its office for those individuals who request to take a copy with them.

I certify that I have read, understand and agree to all disclosures contained in this Patient Information packet.

Patient/Guardian Signature _____ Date _____