PATIENT INFORMATION

Patient Name: Last_____First_____MI _____Preferred_____

Gender: ☐ Male ☐ Female **Family Status**: ☐ Married ☐ Single ☐ Child ☐ Other **Language:**_____

Social Security #: _____ **Birth Date**: _____**Driver's License#**_____

Phone Numbers: **Home:** _____ **Work**: _____ **Ext**: _____**Ethnicity:**_____
***Cellular**: _____ ***E-mail**: _____**Race:**_____

*Our office uses e-mail and text messaging to inform you of required appointment confirmation, changes or availability and discounts.

Address: _____
Street Apartment #

_____
City State Zip Code

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies _____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur / MVP
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due Date:
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease

ALLERGIES
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Sulfa Allergy
☐ Egg Allergy
☐ Latex Allergy

☐ **Premed Needed**

Currently taking any Medications?
Yes
No

Please list below:
_____
_____
_____

Have you ever been diagnosed with or taken medication for osteoporosis? _____

Do you smoke? _____ If yes, how much? _____

Do you drink alcohol? _____ If yes, how much? _____

Do you do recreational drugs? _____ If yes, what kind and how much? _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____
Signature of patient, parent or guardian Date

INSURED OR RESPONSIBLE PARTY INFORMATION

The following is for: ☐ yourself ☐ the patient's spouse ☐ the person responsible for payment ☐ the insured

Name: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ Work: _____ Ext: _____ Cellular_____

Address: _____
Street Apartment #

_____
City State Zip Code

INSURANCE INFORMATION (PRIMARY)

Insurance Plan Carrier: _____ID #: _____ Group #:_____

Name of Insured: Last_____ First_____ MI___ Insured's Birth Date: _____

Insured's Address: _____
* Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

INSURANCE INFORMATION (SECONDARY)

Insurance Plan Name and Address: _____

Name of Insured: _____Last_____First_____ MI___

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Google ☐ Social Media ☐ Insurance ☐ Health Fair ☐ Other _____

Name of person, even, school or office referring you to our practice_____

EMPLOYMENT INFORMATION

The following is for: ☐ The patient ☐ The patient's spouse ☐ The person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

CONSENT FOR SERVICES

As a condition of your 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 and financial responsibility on the part of each patient must be determined before treatment. We require an appointment confirmation at least 24 hours in advance or your appointment could be cancelled.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished 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 patients insurance forms or assist in making collections from insurance companies and will credit any such 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.

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. 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 at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian/ guarantor of payment/responsible party

I give permission to release any protected information to the following people: _____

_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT (HIPAA), 1996

http://www.hhs.gov/ocr/hipaa/finalreg.html

Print Name

I _____ , have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY

Higginbotham Family Dental

WRITTEN FINANCIAL POLICY

Thank you for choosing Higginbotham Family Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, Mastercard, Discover Card, American Express or our Discount Dental Plan

We offer a 5% discount to patients who do not have dental insurance and pay for their treatment in full with cash/check prior to completion of care for procedures over $300.

-There will be a $25 charge to your account for returned checks from your bank for any reason.

-Upon non-payment, if your account is sent to collections, we will charge a 10% collections/legal fee.

- NO INTEREST[1] Payment Plans[2] from CareCredit and In-house financing.

1. Allow you to pay over time with NO INTEREST[1]
2. Convenient, low monthly payment plans[2] also available
3. No annual fees or pre-payment penalties

Please note:

Higginbotham Family Dental requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For plans requiring multiple appointments, alternative payment arrangements may be provided.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[3] **However, the patient understands that the insurance is an agreement between the insured and the insurance company, not the insurance company and Higginbotham Family Dental**. The patient also understands that they are responsible for their balance regardless of their insurance.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

I agree that the facility, Higginbotham Family Dental, or any other collection or servicing agency or agencies retained by the facility (together referred to hereafter as “collectors”) to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including by not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or is otherwise associated with my account.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

Fee estimates are only valid for 90 days and are subject to change.

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

[2]Subject to credit approval

[3]However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Higginbotham FAMILY DENTAL

APPOINTMENT NO-SHOW/ LATE CANCELLATION POLICY

Dear Patient:
We are so excited to have you as a patient, and would really appreciate you contacting us immediately if you are not able to make your scheduled appointment. We ask that you give us at least 24hr notice. This courtesy makes it possible to give your reserved time slot to another patient.

Repeated cancellations, or 3 no shows/no-call appointments with a 12 month period, may result in loss of future appointments, or dismissal from our practice.

Thank you for choosing Higginbotham Family Dental for your dental care needs!

Printed Name Date

Signature