office use only

PT. #

Date

PATIENT INFORMATION RECORD

Patient Name _____ **Date of Birth** / / **SSN#** _____

Address _____ **D.L. #** _____

City _____ **State** **Zip** **Home Ph #(** **)** _____

Employer _____ **Work Ph# (** **)** _____

Spouse's Name _____ **Date of Birth** / / **SSN#** _____

Nearest Local Relative _____ **Phone#** _____

In case of emergency, contact _____ **Phone #** _____

Physician's Name _____ **Referred by** _____

Under Physician's care now? Y N Nature of Treatment – _____

Taking any medication? Y N Please list _____

Drug Allergies? Y N Please list _____

Previous Pre-medication for Dental Treament? _____

			Comments
History of excessive bleeding	Y	N	
Abnormal reaction to anesthetic	Y	N	
Infectious Hepatitis	Y	N	
AIDS/HIV Positive	Y	N	
Venereal Disease	Y	N	
Tuberculosis	Y	N	
Heart Condition/Valve replacement	Y	N	
Rheumatic Fever	Y	N	
Diabetes	Y	N	
High Blood Pressure	Y	N	
Hip/Knee/Joint preplacement	Y	N	
Radiation/Chemotherapy for Cancer	Y	N	
Head or neck surgery	Y	N	
Asthma	Y	N	
Currently Pregnant	Y	N	
Previous Hospitalization	Y	N	*Nature of treatment*

Date of last dental visit / / **Reason for today's visit** _____

Dental Insurance? Y N **Company–** _____ (copy of card is required)

Payment or Co-Payment Method (circle one) CASH CHECK (photo I.D. required) VISA/MC

Person financially responsible (GUARANTOR) for bill _____

Address _____ **Phone #** **SSN#** _____

I understand and agree that *(regardless of insurance status)* I am ultimately responsible for the balance on my account for any professional services rendered. I certify the above information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or this information.

Signature _____ **date** _____

Parent (if patient is a minor) _____ **date** _____

Edward L. Staudt, D.D.S. Kenneth L. Staudt, D.D.S., M.P.H.

ABOUT FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by your dentist. We accept cash, checks, and MasterCard. We will be happy to help you process your insurance claim form for your reimbursement. Any such request must be accompanied by a **completed** insurance form for each visit. In **special** instances we may accept assigment of insurance benefits.

Returned checks, and balances older than 30 days will be subject to additional collection fees and interest charges. There will not be a charge for a broken appointment if you give us **at least 24 hours prior notice.**

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

Please realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. In many instances, your insurance company is not allowed to release payment information to us.
2. Our fees are considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of U.C.R. U.C.R. is defined as usual, customary, and reasonable fees for this region. Thus, our fees are considered usual, customary, and reasonable by most companies.

   This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. *One example is dental sealants.*

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are *your* responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Please complete the following:

I fully understand the financial and insurance guidelines stated above. I also authorize the relase of any information pertinent to my case to any insurance company, adjuster, or counsel involved in this case.

Signature of Policyholder **Date**

Signature of Claimant, if other than Policyholder **Date**

944 Bridgewater Drive, #2-B, Port Orange, Florida 32129 (386) 756-8953

HIPAA PRIVACY FORM
Acknowledge of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You may refuse to sign this acknowledgement****

I,_____, have received a copy/explanation of this office's Notice of Privacy Practices.

_____

(Signature of Patient and/or Guardian) (Date)_____

(Relationship to Patient) Self or Other: _____

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 (such as a language barrier) prohibited obtaining the acknowledgement

[ ] An emergency situation prevented us from obtaining acknowledgement at time of service

[ ] Other (Please specify)

_____

_____