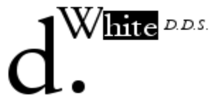
# Patient Information




Date: ______________________________

Last Name: __________________________________ First Name: _______________________________

Title: Mr. Mrs. Dr. Sr. Miss _______________ Nickname: ___________________________________

Sex: _______________ Marital Status: M S D W ______ Date of Birth________________________

Patient Place of Employment: ______________________ Occupation: ____________ Patient Soc. Sec. # ____________

PATIENT'S ADDRESS: _________________________ CITY: ____________________ ST: _________ ZIP: _____________

PATIENT'S TELEPHONE – HOME: __________________ WORK: _______________ CELL: ____________ PGR: ________

NAME OF PERSON PAYING FOR SERVICES: ______________________________________________________

ADDRESS: _________________________________ CITY:_______________________ ST: ________ ZIP: _____________

TELEPHONE – HOME: ___________________ WORK: _______________ CELL: ____________ PGR: ________________

E-MAIL ADDRESS: ____________________________________________________________________________________

REFERRED BY: ______________________________________________________________________________________

***IF FAMILY MEMBER HAS INSURANCE INFORMATION ON RECORD SKIP THIS SECTION***

NAME OF EMPLOYEE WITH INSURANCE: _____________________________________________________________

WHERE ARE THEY EMPLOYED (GROUP NAME): _______________________________________________________

Group #: __________________________ NAME OF INSURANCE CARRIER (OFFICE): _______________________

INS. CO. ADDRESS: ______________________________ CITY: ___________________ ST: ____ ZIP: ____________

INS. CO. TELEPHONE #: (____) ____-_____

EMPLOYEE'S SOC. SEC. #:______-____-_______ EMPLOYEE'S BIRTH DATE: __________________

EMPLOYEE'S SEX: PATIENT'S RELATIONSHIP TO EMPLOYEE:

PHYSICIAN: _______________________________ DATE OF LAST MEDICAL EXAM : _________________

** PLEASE CIRCLE – IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

| | | |
|---|---|---|
| High Blood Pressure | AIDS of HIV Positive | Chemotherapy |
| Low Blood Pressure | Hepatitis A or B | Sinus Trouble |
| Mitro-Valve Prolapse | Venereal Disease | Drug Addiction |
| Heart Murmer | Tuberculosis | Alcohol Addiction |
| Surgery | Asthma / Emphysema | Epilepsy |
| Artificial Joint Replacement | Anemia | Chronic Headache |
| Fainting or Dizzy Spells | Hemophilia | Stoke |
| Rheumatic Fever | Depression | Diabetes |

ARE YOU ALLERGIC TO ANY MEDICATIONS? _______ IF YES, WHICH ONES: _____________________________________

ARE YOU TAKING ANY MEDICATIONS NOW? ______ IF YES, WHICH ONES: _____________________________________

DO YOU HAVE ANY MEDICAL PROBLEM NOT LISTED? _______________________________________________________

ARE YOU PREGNANT? _________IF YES, WHEN ARE YOU DUE?________________________________

DO YOU USE TOBACCO IN ANY FORM? YES______ NO______ SMOKE_____ CHEW_______

IF YES, HOW LONG HAVE YOU USED TOBACCO? YEARS______ MONTHS_________

IF NO, HAVE YOU EVER USES TOBACCO IN THE PAST? YES______ NO_____

HOW LONG AGO DID YOU STOP? YEARS______ MONTHS_________

LAST VISIT TO DENTIST ___________________________ WHAT WAS DONE? ___________________________________________

LAST X-RAYS TAKEN _____________________________ HOW OFTEN DO YOU BRUSH? ____________ FLOSS? _______________

ARE YOU HAVING ANY DISCOMFORT ___________ PAIN IN EARS OR JAW, ___ _____ NASAL OBSTRUCTION ________________

SWELLING OR LUMP IN MOUTH_______, OR POPPING OR CLICKING WHEN YOU CHEW ________,

BAD TASTE OR SMELL,_________, BLEEDING GUMS________________.

EXPLAIN ___________________________________________________________________________________________________

ARE YOU INTERESTED IN BRIGHTENING YOUR SMILE? Y OR N

I HAVE REVIEW THE PREVIOUS INFORMATION AND AGREE TO ITS TERMS.

SIGNATURE OF PATIEN (PARENT IF A MINOR) _____________________________________________________________

211 Saint Peter Street • South Bend, IN • 46617-2823 • 574 – 288- 9400 • Fax 574.288.7100
***Web*** www.DrDanWhite.com • ***Email*** danielwhitedds@gmail.com

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

**SECTION A: PATIENT GIVING CONSENT**

Name: ___________________________________________________________________________________

Address: _________________________________________________________________________________

Telephone: __________________________________ E-mail: ___________________________________________

**SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

**NOTICE OF PRIVACY PRACTICES**: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before singing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Anne DeWinter
Telephone: (574) 288-9400 Fax: (574) 288-7100
E-Mail: danielwhitedds@gmail.com
Address: 211 N Saint Peter Street, South Bend, IN 46617

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocations submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received our revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**SIGNATURE**

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 this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: __________________________________________________________________

Relationship to Patient: ________________________________________________________________________

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# OUR FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a copy of our Financial Policy, which we require you to read and sign prior to treatment.

- FIRST VISIT - CHARGES NEED TO BE PAID IN FULL.
  IF YOU HAVE INSURANCE WE WILL FILE IT AND THE INS. WILL PAY YOU. IF IT IS A HYGIENE APPOINTMENT, YOU NEED TO PAY AT THE TIME OF SERVICE, WHAT WE ESTIMATE THAT THE INSURANCE WILL NOT COVER.

- AFTER THE 1ST VISIT
  - SERVICES $100.00 OR LESS – FULL PAYMENT
  - SERVICES OVER $100.00 – ½ OF YOUR PORTION, WITH A MINIMUM OF $100.00 PAYMENT
  - MAJOR WORK (CROWNS, BRIDGES, PARTIALS, DENTURES) – ½ OF THE PATIENT PORTION IS DUE AT THE TIME OF THE APPOINTMENT AND THE BALANCE PAID OVER 2-3 MONTHLY PAYMENTS.

- WE ACCEPT CASH, CHECK, VISA AND MASTERCARD.

- FINANCE CHARGE - A CHARGE WILL BE ADDED TO ANY ACCOUNT THAT HAS A BALANCE THAT IS 90 DAYS OLD.

**REGARDING INSURANCE**

We accept assignment of insurance benefits. However, we do require you to pay your deductible and co-payment at time of service. We need a completed insurance form and copy of benefits. If services are for major dental work (crowns, bridges, partials, dentures) then we will accept ½ of your portion at the time of service and the remaining balance over 2-3 months. Your insurance is a contract between you and your insurance company. We are not a party to the contract. If your insurance company has not paid your account in full within 45 days, the balance will then be due by you. Please be aware that some, perhaps all, of the services provided may be non-covered and not considered reasonable by your insurance policy.

**Usual and Customary**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment, regardless of any insurance company's arbitrary determination of usual and customary rates.

**Missed Appointments**

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Thank you for understand our Financial Policy. Please let us know if you have any questions or concerns.
I have read the Financial Policy. I understand and agree to this Financial Policy.

X ____________________________________________________ Date ________________________

Signature of Patient or Responsible Party

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# Acknowledgement of Receipt of Notice of Privacy Practices

I, ________________________________________, have received a copy of this office's Notice of Privacy Practices.

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

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________