Robertsdale Dental Care

About You

Today's Date:_____

Name:_____ I prefer to be called:_____
Last First M.I.

Birthdate:_____/_____/_____ S. S. #:_____-_____-_____ Drivers License:_____
State Number

Street Address:_____
and Street City State Zip
Mailing Address:_____
P. O. Box City State Zip

Home Phone #_____ Work #_____ Cell/Pager #_____

We email birthday coupons! Email Address:_____

How did you find out about our office?_____

What pharmacy do you use?_____

Employer & Address:_____ Occupation:_____

Spouse:_____ Birthdate:_____/_____/_____ Employer:_____

Emergency Contact Person:_____

Relation:_____ Home Phone #_____

Address:_____
P. O. Box/Street City State Zip

Person Responsible for Account

Name:_____ Relationship:_____ S. S. #:_____-_____-_____

Address:_____

Home Phone #:_____ Work Phone #:_____

Insurance Information

We will file your insurance on your behalf as a service to you. There is no guarantee of payment. Please check below what type of insurance you have.

☐ Dental Insurance Name:_____ ☐ Medical Insurance Name:_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____and assign directly to Robertsdale Dental Care the benefits that were otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Robertsdale Dental Care to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. **I understand that payment is my obligation regardless of insurance or any other third party involvement.**

Signature:_____Date:_____

Medical History

Robertsdale Dental Care

Patient Name:

Do you have a personal physician? ☐ Yes ☐ No Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Physician's Name:_____ Date of Last Visit:_____ Phone #:_____

Are you currently under the care of a physician? ☐ Yes ☐ No Please explain:_____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No Have you ever been involved with dental/medical legal activity? ☐ Yes ☐ No

Allergies: Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Sedatives	Y N Barbiturates
Y N Jewelry	Y N Sulfa Drugs	Y N Codeine	Y N Latex
Y N Tetracycline	Y N Dental Anesthetics	Y N Penicillin	Y N Other

If yes to any of the above, explain reaction:_____

List additional drugs that cause allergic reactions:_____

Current Medications & Prescriptions: Are you taking any of the following? Circle Y or N & list prescription

Y N Acetaminophen	Y N Blood Pressure Medication	Y N Bisphosphonates	Y N Osteoporosis Medication
Y N Antibiotics	Y N Cold Remedies	Y N Steroids/Cortisone	Y N ADD/ADHD Medication
Y N Antihistamines	Y N Digitalis/Heart Medication	Y N Thyroid Medicine	Y N Other
Y N Aspirin	Y N Insulin/Diabetes Drugs	Y N Tranquilizers	
Y N Blood Thinners	Y N Nitroglycerin	Y N Recreational drugs	

Please list the Name of ALL Medications circled above & any other prescriptions/over-the-counter drugs not listed:_____

_____

Medical History: Do you have or have you experienced any of the following?

Y N Abnormal Bleeding	Y N Alcohol Abuse	Y N Arthritis	Y N Liver Disease
Y N Artificial Valves	Y N Asthma	Y N Blood Transfusion	Y N Radiation Treatment
Y N Chemotherapy	Y N Colitis	Y N Congenital Heart Defect	Y N Sinus Problems
Y N Difficulty Breathing	Y N Drug Abuse	Y N Emphysema	Y N Ulcers
Y N Fainting Spells	Y N Glaucoma	Y N Headaches	Y N Fatigue
Y N Heart Murmur	Y N Heart Surgery	Y N Hepatitis	Y N Lack of motivation
Y N HIV+/AIDS	Y N Hospitalized	Y N Kidney Problems	Y N Excessive sleepiness
Y N Low Blood Pressure	Y N Pacemaker	Y N Mitral Valve Prolapse	Y N Anxiety/Depression
Y N Rheumatic Fever	Y N Scarlet Fever	Y N Seizures	Y N Loud snoring
Y N Stroke	Y N Thyroid Problems	Y N Tuberculosis (TB)	Y N Morning headaches
Y N Artificial Bones/Joints	Y N Cancer	Y N Diabetes	Y N Difficulty concentrating
Y N Epilepsy	Y N Heart Attack	Y N High Blood Pressure	Y N Night-time sweating
Y N Counseling for alcohol and/or prescribed drugs?		Y N Autism	Y N ADD/ADHD

Y N Surgery List surgeries:_____

Has any doctor recommended pre-medication with antibiotics before dental appointments for any reason? If so, please explain:_____

Please list any serious medical condition(s) you have experienced: _____

Authorization

I affirm that the information I have given is correct to the best of my knowledge. It will be held in strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

Patient Signature _____Date _____

Print Name _____

Doctor Signature _____ Date_____

Privacy Agreement/Financial Policy

Dr. Northcutt, Associates and Staff (collectively labeled Dentist) agree to maintain Privacy of our patients as outlined in this HIPAA form. The Dentist takes pride in being able to extend a greater degree of privacy than is required by HIPAA, state confidentiality mandates, and common law.

Dentist agrees to never sale lists of patients or protected health information to companies to market their products or services directly to patients without authorization. In consideration for treatment and the above noted patient protection, Patient agrees to refrain from directly or indirectly publishing or airing commentary upon Dentist and his practice, expertise and/or treatment unless explicitly mandated by law. This shall include comments on web pages, blogs, social media, and/or mass correspondence.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

Patient Signature_____ Date_____

Patient Name (printed) _____ _____

Financial Policy

Thank you for choosing Robertsdale Dental Care as your provider. To better serve you, we ask all patients to complete our new patient information form completely before seeing the dentist or hygienist. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

ALL INSURANCE COPAYMENTS, DEDUCTIBLES, AND ESTIMATED PATIENT PORTIONS ARE DUE ON THE DATE TREATMENT IS PERFORMED.

INSURANCE

We are happy to accept assignment of insurance benefits from your insurance carrier. Although Dr. Hardy and Dr. Taylor are the only preferred providers (in network) for Blue Cross Blue Shield of Alabama, we will gladly file your claim if benefits are available. As a courtesy to you, we will file your insurance, help you maximize your benefits, and estimate both your insurance coverage and your portion due. Your estimated portion is due upfront (before treatment) on date of service. Should your insurance company refuse to comply with assignment of benefits, you may be asked to pay your bill in full and be reimbursed by your insurance company. **The balance is the patient's responsibility whether the insurance company pays or not.** If the insurance company has not paid the account in full within 45 days, the balance becomes the patient's responsibility. Should Robertsdale Dental Care have to expend any fees (collection, court cost, etc.) to collect any payment portion, insurance or other, these fees will automatically become the patient's responsibility. Please be aware that some and perhaps all of the services provided may be non-covered and not considered reasonable and necessary under some dental insurance policies.

PAYMENT OF SERVICES

Your estimated payment portion is due in full on the date of service. Payment for sedation surgery needs to be paid in full prior to scheduling the sedation appointment.

RETURNED CHECK FEE/PAYMENTS

Any returned check will incur a $30.00 NSF fee. Robertsdale Dental Care accepts Cash, Check, Credit card, Care Credit, and Lending Club.

MINOR PATIENTS

The adult accompanying a minor is responsible for seeing that payment is made in full. For unaccompanied minors, non-emergency treatment will be denied unless prior arrangements have been made for payment by cash, check, or credit card.

MISSED APPOINTMENTS

Please help us serve you better by keeping scheduled appointments. If an appointment must be rescheduled, please give us at least 24 hour notice. Failure to give a 24 hour notice will result in a $50 missed appointment fee. Should the problem continue, you may be asked to prepay for appointments to reserve the appointment time.

AGREEMENT TO PAY COLLECTION FEES ADDED TO ACCOUNT BALANCES

I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and /or court costs, if such are necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State.

CONSENT TO CONTACT PATIENT BY CELL PHONE OR E-MAIL

You agree, in order for us to service your account or to collect monies you may owe, Robertsdale Dental Care and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which can result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

Please let us know if you have any questions or concerns regarding our Financial Policy. We look forward to serving your dental needs. **I have read the Financial Policy. I understand and agree to this Financial Policy.**

Signature of Patient or Responsible Party _____ Date _____

INFORMED CONSENT FORM FOR GENERAL DENTAL PROCEDURES

You, the patient, have the right to accept or reject dental treatment recommended by your dentists. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment until you discuss potential benefits, risks and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialist, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome. As with all surgery/dental procedures, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he/she can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes or if you are taking antibiotics.

Further, understand that you are entering into a contractual relationship with Robertsdale Dental Care for professional care. Understand that meritless and frivolous claims for dental malpractice have an adverse effect upon the cost and availability of dental care, and may result in irreparable harm to a dental provider. As additional consideration for professional care provided to you by Robertsdale Dental Care, you, the patient/guardian and/or your representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of dental malpractice against Robertsdale Dental Care.

Furthermore, should a meritorious medical/dental malpractice case or cause of action be initiated or pursued, you (the patient) and/or your representative agree to use board-certified expert witness(es) in the same specialty as Robertsdale Dental Care. You also agree that these expert witnesses will adhere to the guidelines and/or code of conduct defined for expert witnesses by the ADA.

In an effort to control the increasing costs of dental care, any claims or disputes against this office shall be resolved by "binding arbitration". By signing this agreement, the patient agrees with the office of Robertsdale Dental Care, that any dispute relating to dental or medical care services rendered for any condition, including any services rendered prior to the date this agreement was signed, and any dispute arising out of the diagnosis, treatment, or care of the patient, including the scope of this arbitration clause and the arbitrability of any claim or dispute, against whenever made, (including to the full extent permitted by applicable law third parties who are not signatories to this agreement [including associates] shall be resolved by binding arbitration by the National Arbitration Forum, under the Code of Procedure then in effect. The patient understands that the result of this arbitration agreement is that claims, including malpractice claims he/she may have against the doctor, cannot be brought as a lawsuit in court before a judge or jury, and agrees that all such claims will be resolved as described in this section.

Robertsdale Dental Care

Please read and initial the items below and sign at the bottom of the form.

1. Treatment to be Provided: I understand that during my course of treatment that the following care may be provided

   Examinations_____ Preventive Services_____ Restorations_____ Crowns Bridges Other_____

   Patient Initials_____

2. Drugs and Medications: I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Patient Initials _____

3. Changes in Treatment Plan: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary. Patient Initials _____

4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. Patient Initials _____

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment. I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I understand that under the Health Insurance Portability and Accountability Act ("HIPAA"), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or been given the opportunity to receive a copy of the Notice of Privacy Practices.

_____ _____

PATIENT DATE WITNESS DATE

_____ _____

PRINT PATIENT NAME PARENT/LEGAL GUARDIAN DATE