Dental Wellness Insurance Information Sheet

Patients with dental insurance coverage please complete the necessary information below. As a service to you, Dental Wellness will assist you in processing insurance claims. However, you are completely responsible for all fees.

Insured is ☐ Self ☐ Husband ☐ Wife ☐ Mother ☐ Father

Employee's Name _____ Employee's Social Security # _____

Insurance Co _____ Group #_____ Employee's Date of Birth _____

Ins. Co. Address _____ Insurance Co. Phone _____

Are you covered by a 2nd insurance company? ☐ YES ☐ NO

If yes, name of 2nd insurance company _____ Group # _____

Employee name for 2nd insurance company_____ SS# for 2nd Ins. Co _____

Employee birthday for 2nd insurance company _____

MUST COMPLETE IF UNDER 18 OR FULL TIME STUDENT/RESPONSIBILITY PARTY INFORMATION REQUIRED

Mother's Name _____ Mother's Social Security # _____

Mother's Address _____

Mother's Home Phone Number _____ Birthdate _____

Mother's Employer _____ Occupation_____ Work Phone _____

Father's Name _____ Father's Social Security # _____

Father's Address _____

Father's Home Phone Number _____ Birthdate _____

Father's Employer _____ Occupation_____ Work Phone _____

So you do not have to sign an insurance form at each dental visit, Dental Wellness will maintain this 'signature on file' for you. AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any provider, insurer or other Organization to release any information regarding the dental history, treatment or benefits payable for this claim of the Plan Administrator or its authorized agent for the purpose of determining benefits payable.

X _____ Date _____
Signed (patient parent if minor)

AUTHORIZATION TO PAY BENEFITS TO Dental Wellness, Dr. Sanya Sweeney, or Dr. Douglas Cohen for serviced rendered.

X_____ Date _____
Signed (patient parent if minor)

*Please print clearly

Welcome to Dental Wellness

PATIENT INFORMATION

First Name: _____ Initial: ___ Last Name: _____

Address: _____ City: _____ State: _____ Zip:_____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone :_____

Social Security #: _____ Driver License: _____ State: ____ Exp date: _____

Sex: M/F Birthdate: _____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employer: _____ Occupation: _____

Are you a full time student? Y/N If so, which school? _____

Email: _____

Spouse's Name: _____ Spouse's Social Security #: _____

Spouse's Birthdate: _____ Spouse's Employer: _____ Occupation:_____

Person to notify in an emergency (not at home address): _____ Phone: _____

How did you learn about our office? _____

Do you consider yourself to be a ***proactive person***? Someone wo likes to avoid complications. Who'd rather take care of an issue today instead of letting it worsen over time which might cost more time, visits, money, and/or pain to fix down the road?
☐ Yes ☐ No

Do you consider yourself more of a ***reactive person***? Someone who would rather wait and deal with any issues as they develop. Even if it means costing you more time, visits, money, and/or pain to fix down the road?
☐ Yes ☐ No

What do you ***most value*** in your dental care?
- ☐ Cosmetic – You most value how teeth look. You want them straight, white.
- ☐ Function – You most value an ability to enjoy your favorite food or drink.

Would you like to hear about our payment plans if needed? Y/N

MEDICAL HISTORY

Your current physical health is ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? **Y/N**

If yes, please explain: _____

Physicians name: _____ Phone #: _____

Do you require antibiotics before dental treatment? **Y/N** Reason: _____

Allergic to any medications? **Y/N** If yes, please list _____

Are you taking any medications? **Y/N** (If yes, please list each one with dose/frequency below)

_____

*Please Turn Over

Please indicate with a ✔ if you have OR you have had following:

☐ Allergies to anesthetics	☐ Excessive bleeding from cut or extraction	☐ Radiation Treatments
☐ Anxiety-Medicated	☐ Eye Disorders	☐ Rheumatic Fever
☐ Artificial Replacement where_____	☐ High Blood Pressure Medicated Y/N	☐ Sinus problems
☐ Anemia or blood problems	☐ Immune System Disorders(AIDS,HIV,ARC)	☐ Smoke-per day _____
☐ Any heart ailments	☐ Hay fever or Allergies in general	☐ Stroke-Date _____
☐ (please explain below)	☐ Kidney Problems	☐ Thyroid
☐ Arthritis	☐ Liver problems or Hepatitis (A,B,C)	☐ Tonsillitis
☐ Asthma-Inhaler Y/N	☐ Malignancies	☐ Tuberculosis
☐ Cancer-Type _____	☐ Neurological Problems	☐ Ulcer or Colitis
☐ Diabetes Medicated Y/N	☐ Pregnant-Month _____	☐ Venereal disease-Herpes
	Psychiatric Care/Mental Health Illness	☐ Other

Please add any information that you feel is important:

_____

DENTAL HISTORY

Reason for visit: _____
Approximate date of last dental visit: _____
Have you ever had any serious problems associated with previous dental treatments? Y/N
If so, please explain: _____
What did or did not happen before at the dentist, that was the reason for you not to return?
_____

How often do you brush? _____ How often do you floss (routinely)? _____
What type of brush do you use? ☐ Soft ☐ Medium ☐ Hard Electric **Y/N** If yes, what brand _____

Do you notice a bad taste in your mouth? **Y/N**
Do you lose fillings or break fillings? **Y/N**
Do you chew on one side of your mouth? **Y/N**
Do your gums feel tender and swollen? **Y/N**
Do you ever feel/been told that you do not have fresh breath? **Y/N**
Do you have loose teeth **Y/N**
Do you usually get a lot of cavities? **Y/N**
Do your gums bleed? **Y/N**

Do you have missing teeth? **Y/N** If yes, did you replacement them? **Y/N**
If not, would you like to learn about your options to replace them? **Y/N**
Do you have a denture? **Upper**: Full/Partial age _____ **Lower**: Full/Partial age _____

Which food causes you twinges of pain? ☐ Hot ☐ Cold ☐ Sweet ☐ None

Do you clench or grind your jaw while you are sleeping or during the day? **Y/N**
Does your jaw feel tired? **Y/N**
Do you experience popping/clicking/sounds in your jaw joints? **Y/N**
Do you have jaw and neck pain? **Y/N**
Please add any information that you feel is important: _____

I authorize the use of my radiographs and/ or photos for use on seminars, publications, social media, and the website of Dental Wellness.

X _____ Date _____
Signed (patient or parent of minor)

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of 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.

X _____ Date _____

The highest compliment our patients can give us is the referral of their friends or family. Thank you for your trust.

Patient Screening Form

ADA

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.

Dental Wellness Covid-19 Check in Procedures

- Call the office from your car when you arrive
  Riverton: 856-829-0030 Marlton: 856-983-2232
- Please stay in your car unless instructed differently, when entering the office please wear a mask and wait to be greeted at the door. We suggest leaving all personal belongings in your car if possible including any outerwear. If you are unable to wait in your car, please observe appropriate social distancing in the waiting area.
- Your temperature will be taken upon entry with a no touch thermometer.
- Hand your completed Covid-19 screening form to the employee at the reception area. A blank copy can be found on our website: thedentalwellness.com. Your cell number will be confirmed and we may ask you to wait in your car. If you do not have a copy of the Covid-19 screening form we will supply you with one and ask that you return to your car and complete the form.
- We will call you by telephone when we are ready to see you. If you do not have a cell phone let us know where you are parked and watch the door for someone to wave you in. Enter the office and someone will be there to greet and escort you directly to your prepared room.
- If you are with someone we ask that they wait in the car, if they absolutely cannot they may sit in waiting area we request they practice appropriate social distancing.

FINANCIAL POLICY DISCLOSURE
CONSENT FOR TREATMENT

Dental Wellness is dedicated to providing you with the best possible care while striving to maintain professional fees at reasonable levels. We appreciate your review of, and compliance with, the following policies:

- For all services rendered, payment or provision for payment by insurance or financial plans is expected at the time of service.
- Please remember, your insurance coverage is an agreement between you and your insurer. We do the very best to gather information to give you an estimate of your portion. Denial of payment by them, and any deductibles and co-payment are your responsibility. We participate with many insurers. This means we accept the provisions of these many plans. Some pay in full, and some only pay a portion of the fee. We will bill your insurance company directly. Payment received from them will be credited to your account. A statement will advise you of any unpaid balance. Applicable co-payments, deductibles and fees for non-covered procedures are due at the time of services rendered.
- If you have dual insurance, please be aware that as a courtesy to you, we will submit your secondary insurance claim; however your co-pay is based from your primary insurance and is due at the time of service. Any payment from your secondary insurance will be sent to you, the patient.
- If we do not participate with your insurance company, payment is due at the time of service. We will provide you with a statement you can use to collect payment from your insurer.
- Four your convenience, we accept Visa, Master Card, Discover, AMEX, checks and cash.
- Accounts over 30 days past due, will accrue a late charge, and all balances over 120 days past due will be sent to court for collection. Checks returned by your bank will result in a $35.00 charge. Any patient with a delinquent account must satisfy the balance prior to any further treatment. Also, any further treatment must be paid for, in full, at the time of the service.
- Cancellations must be made at least 48 hours in advance, all appointments that are cancelled within the 48 hours or missed appointments will both have a $50.00 charge for each hour of your appointed time.

CONSENT

I give consent for myself/my child to receive dental treatment deemed necessary by the providers at Dental Wellness. These procedures include, but are not limited to: examinations, oral prophylaxes, fluoride treatments, sealants, restorations, periodontal treatment, endodontic treatments, extractions, and the use of local anesthetics. This consent shall be considered in effect until rescinded or revoked.

X_____ Date_____

(Signature of patient/or parent if minor)

Dental Wellness of Riverton
Dental Wellness of Marlton
HIPAA Privacy Authorization Form

*Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

AUTHORIZATION

I authorize Dental Wellness to use and disclose the protected health information described below to _____(individual seeking the information).

EFFECTIVE PERIOD

This authorization for release of information covers the period of healthcare from: (circle one)

a. _____ to _____
or
b. all past, present, and future periods.

EXTENT OF AUTHORIZATION (circle one)

a. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
Or
b. I authorize the release of my complete health record with the exception of the following information:
__ Mental health records
__ Communicable diseases (including HIV and AIDS)
__ Alcohol/drug abuse treatment
__ Other (please specify): _____

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____
Signature of patient or personal representative, parent of patient is a minor

Date: _____