MOONLIGHT BEACH DENTAL

Personal Information

First name: _____ Middle initial: _____ last name: _____ Social Security # _____

I prefer to be called: _____ Gender: ☐ Male ☐ Female Date of Birth: _____

_____

Street address City State ZIP

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

Primary contact number (Check one): ☐ Cell ☐ Work ☐ Home Email: _____

Employer: _____ whom may we thank for referring you? _____

Emergency contact person: _____ Emergency contact phone number: _____

Insurance Information

Primary insurance company name: _____ Subscriber's name: _____

Subscriber's ID # _____ Group # _____ Relationship to patient: _____

Insurance telephone # _____ Subscriber's date of birth: _____

Secondary insurance company name: _____ Subscriber's name: _____

Subscriber's ID # _____ Group # _____ Relationship to patient: _____

Insurance telephone # _____ Subscriber's date of birth: _____

Moonlight Beach Dental Financial Policy

Our mission is to deliver the finest, most cost-effective health care treatment available today. Following diagnosis, the doctor will advise you of our plan for treatment. Additionally, we will discuss with you the investment in today's and future treatment.

Payment is due at the time services are rendered. For your convenience we accept cash, personal check, Visa, MasterCard, Discover and American Express. We also offer convenient payment options through Care Credit and Lending Point Solutions.

Insurance benefits are determined by your employer and not your dentist. Any deductible or estimated co-payment amount will be due at the time of treatment. Insurance is not a guarantee of payment; insurance companies may not pay for all your costs. Your insurance policy is a contract between you and your insurer.

As a courtesy we will be glad to file your claim for you provided we have complete and accurate insurance information. You will be expected to pay for services rendered if the office is unable to verify your insurance information prior to treatment. If payment for services already rendered has not been paid within 45 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible. Should additional means of collection become necessary, all costs of collection, including attorney fees, court costs and collection agency fees (35% standard collection/50% legal collection) will be added to your existing balance. Your cooperation with this policy will assure equitable treatment of insured and non-insured patients.

We reserve the right to charge and collect fees for broken appointments. Appointments are reserved exclusively for you. We consider an appointment confirmed once the appointment is scheduled. **A minimum charge of $50 per hour may be posted to your account if an appointment is cancelled without a 48 hour advance notice.** As a health benefit to you, we may offer to move your appointment to an earlier time if openings arise.

Any accounts overdue for patient payment in excess of 45 days are subject to an interest fee of 18% per annum. A returned check fee of $25 will be added to your account balance for any checks returned to us as non-sufficient funds (NSF).

Payment plans and financial arrangements can be entered into for comprehensive dental treatment, prior to commencing treatment.

I, the undersigned, authorize payment of the dental benefits otherwise payable to me, directly to Nicole Vane D.M.D.

I have read and understand this financial policy.

_____ _____ _____

Patient/Legal Guardian's signature **Today's date** **Relationship to patient**

MOONLIGHT BEACH DENTAL

Dental/Medical History

Reason for today's visit: _____ Are you currently in pain? ☐ Yes ☐ No

If so, please describe: _____

Have you ever had trouble with previous dental treatment? ☐ Yes ☐ No If so, please describe: _____

Approximate Date of last cleaning: _____ Procedure(s) done at last dental visit: _____

Are you looking for a change in the way your smile looks? ☐ Yes ☐ No

If you could change anything about your teeth, it would be (Check all that apply)

- ☐ Color of teeth
- ☐ Color of your teeth
- ☐ Size/Shape of your teeth
- ☐ Gaps between your teeth
- ☐ Too much or too little of teeth show when you smile
- ☐ Too much or too little gum shows when you smile
- ☐ Alignment of your teeth
- ☐ Sensitive or receding gums

Do you have? (Check all that apply)

- ☐ Missing teeth
- ☐ Teeth sensitive to heat/cold
- ☐ Concerns about bad breath
- ☐ Worn/broken/chipped teeth
- ☐ Old crowns that have dark edges at the top
- ☐ Teeth sensitive while chewing
- ☐ Old or discolored fillings

Have you ever experienced? (Check all that apply)

- ☐ Periodontal disease/gum treatment
- ☐ Orthodontics treatment
- ☐ Oral surgery/ Wisdom Teeth
- ☐ A bite plate or mouth guard
- ☐ Snoring
- ☐ Discomfort in your jaw point (TMJ/TMD)
- ☐ Your bite adjusted or balanced
- ☐ Serious injury to the mouth or head
- ☐ Chronic bad breath
- ☐ Grinding of teeth (day or night)

Do you require antibiotics before dental treatment? ☐ Yes ☐ No If yes, why? _____

Have you ever taken, currently take, or plan to take medication for osteoporosis? (Bisphosphonates) ☐ Yes ☐ No

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____

Have you been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: _____

Are you on a special diet? ☐ Yes ☐ No If yes, please explain: _____

Do you use tobacco? ☐ Yes ☐ No Do you use controlled substances? ☐ Yes ☐ No

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Acrylic
- ☐ Metal(s)
- ☐ Latex
- ☐ Sulfa Drugs
- ☐ Other

Women are you?

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

MOONLIGHT BEACH DENTAL

Do you have, or have had, any of the following (Please check yes or no!)?

☐	Yes	☐	No	AIDS/HIV Positive	☐	Yes	☐	No	Cold Sores/Fever Blisters	☐	Yes	☐	No	Hepatitis A
☐	Yes	☐	No	Alzheimer's Disease	☐	Yes	☐	No	Congenital Heart Disorder	☐	Yes	☐	No	Hepatitis B or C
☐	Yes	☐	No	Anaphylaxis	☐	Yes	☐	No	Convulsions	☐	Yes	☐	No	Herpes
☐	Yes	☐	No	Anemia	☐	Yes	☐	No	Cortisone Medicine	☐	Yes	☐	No	High Blood Pressure
☐	Yes	☐	No	Angina	☐	Yes	☐	No	Diabetes	☐	Yes	☐	No	High Cholesterol
☐	Yes	☐	No	Arthritis/Gout	☐	Yes	☐	No	Drug Addiction	☐	Yes	☐	No	Hives or Rash
☐	Yes	☐	No	Artificial Heart Valve	☐	Yes	☐	No	Easily Wounded	☐	Yes	☐	No	Hypoglycemia
☐	Yes	☐	No	Artificial Joint	☐	Yes	☐	No	Emphysema	☐	Yes	☐	No	Irregular Heartbeat
☐	Yes	☐	No	Asthma	☐	Yes	☐	No	Epilepsy or Seizures	☐	Yes	☐	No	Kidney Problems
☐	Yes	☐	No	Blood Disease	☐	Yes	☐	No	Excessive Bleeding	☐	Yes	☐	No	Leukemia
☐	Yes	☐	No	Blood Transfusion	☐	Yes	☐	No	Excessive Thirst	☐	Yes	☐	No	Liver Disease
☐	Yes	☐	No	Breathing Problem	☐	Yes	☐	No	Fainting Spells/Dizziness	☐	Yes	☐	No	Low Blood Pressure
☐	Yes	☐	No	Bruise Easily	☐	Yes	☐	No	Frequent Cough	☐	Yes	☐	No	Lung Disease
☐	Yes	☐	No	Cancer	☐	Yes	☐	No	Frequent Diarrhea	☐	Yes	☐	No	Mitral Valve Prolapse
☐	Yes	☐	No	Chemotherapy	☐	Yes	☐	No	Frequent Headaches	☐	Yes	☐	No	Osteoporosis
☐	Yes	☐	No	Chest Pains	☐	Yes	☐	No	Genital Herpes	☐	Yes	☐	No	Pain in Jaw Joints
☐	Yes	☐	No	Parathyroid Disease	☐	Yes	☐	No	Stroke	☐	Yes	☐	No	Tumors or Growths
☐	Yes	☐	No	Psychiatric Care	☐	Yes	☐	No	Swelling of Limbs	☐	Yes	☐	No	Ulcers
☐	Yes	☐	No	Radiation Treatments	☐	Yes	☐	No	Thyroid Disease	☐	Yes	☐	No	Venereal Disease
☐	Yes	☐	No	Recent Weight Loss	☐	Yes	☐	No	Tonsillitis	☐	Yes	☐	No	Yellow Jaundice
☐	Yes	☐	No	Renal Dialysis	☐	Yes	☐	No	Tuberculosis	☐	Yes	☐	No	Rheumatic Fever
☐	Yes	☐	No	Shingles	☐	Yes	☐	No	Scarlet Fever	☐	Yes	☐	No	Rheumatism

Have you ever had any serious illness not listed above? ☐ Yes ☐ No Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____ _____

Patient/Legal Guardian's signature **Today's date** **Relationship to patient**

_____ _____

Dentist's signature **Today's date**

MOONLIGHT BEACH DENTAL

HIPAA Privacy Policy

Acknowledgement of Receipt of Notice of Privacy Practices

****You May Refuse to Sign This Acknowledgement****

The Health Insurance Portability and Accountability Act (HIPAA), provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Service. www.hhs.gov

We have adopted the following policies:

Patient information will be kept confidential except as is necessary to provide services to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for our care. Patient records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of patient records, PHI and other documents or information.

It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail or by any means convenient for the practice and /or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

We agree to provide patients with access to their records in accordance with state and federal laws.

We may change, add, delete or modify any of these provisions to better serve the needs of both the patient and the practice.

You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I hereby consent and acknowledge my agreement to the terms set forth above and any subsequent changes in office policy.

I, _____have received a copy of this office's Notice of Privacy Practices.
(Please print name)

_____	_____	_____
Patient/Legal Guardian's signature	**Today's date**	**Relationship to patient**

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 acknowledgment
- ☐ Other (Please Specify): _____

MOONLIGHT BEACH DENTAL

OFFICE POLICIES STATEMENT

At our office, it is our primary goal to offer the absolute best dental treatment in a comfortable setting. It is also important to us that you understand our office policies on billing, appointments, x-rays, and insurance. Please read through the information below. If you have any questions about these important office policies, please ask us. Thank you.

PAYMENT AND BILLING:
Payment is due at or before the time of service. Longer and/or more extensive appointments may require an advance deposit. Financing must be arranged and approved at least 24 hours prior to treatment. A $10 overdue balance charge will be added every month to overdue accounts. No fee is charged to accounts kept current. Any account that is 90 days overdue will be referred to an outside agency with collection fees added.

CANCELLATIONS AND MISSED APPOINTMENTS:
When we make you an appointment, we reserve that time especially for you. Therefore, we require minimum one full business days' notice if you must reschedule or cancel your appointment or you will be charged $75 per appointment hour. Friday, Saturday, and Sunday are not business days at this office. So, for example, if you have an appointment on Wednesday that you must cancel or change, we must hear for you by the prior Monday. Please understand that this charge represents our actual cost for idle time, and is not meant as a punishment. In fairness to all of our patients, we cannot make any exceptions to this policy, regardless of reason. We will make every effort to remind you of your appointment(s) by texting, e-mailing and/or calling prior to your appointment, but we cannot guarantee that we will be able to contact you. Please make a note of your appointment time on your calendar rather than relying on a reminder.

TREATMENT PLANS:
We will provide you with a written treatment plan list, including estimated costs. All charges for services provided are ultimately your responsibility, even if our original estimate differs from the final cost. We are happy to discuss your treatment plan/estimate and answer all of your questions before your treatment.

X-RAYS:
X-rays are one of the most important diagnostic tools in the dental office. At this office, we use digital x-ray equipment to minimize radiation. Our standard of care requires a complete series or panoramic x-ray for all adults. These films check for cavities and for pathology in the roots, sinuses, nerves, and jawbones. For children, the number of pictures taken is dependent on age and eruption patterns. We are not able to provide any dental services for patients without x-rays meeting the standard of care. If you have recently had x-rays taken at a previous dental office, please assure that copies are sent to us prior to your visit. If we have not received recent x-rays by your appointment, we will take a new series for you at that visit. For our patients with dental insurance: please note that some insurance companies limit the frequency with which x-rays are covered. Therefore, if you are unable to obtain recent films (a complete set within the past five years) from your previous dentist(s), your new x-rays might not be covered by your insurance.

I, _____ understand these office policies.
(Please print name)

_____ _____ _____
Patient/Legal Guardian's signature **Today's date** **Relationship to patient**

MOONLIGHT BEACH DENTAL

WARRANTY

Our practice is very proud of the dentistry we provide for you and your family. Our goal is not to simply correct any dental problems you have, but to help prevent dental disease in the future to save you time and expense. The long-term success of the treatment we provide depends on you! You should take care of your teeth and gums at home and visit our office for regular professional exams and preventative treatments. Your professionally diagnosed care and recommended treatment varies based on your individual condition. The primary key to your long-term success is spending a few minutes a day on your home care (brushing and flossing along with any prescribed products). The second key to success is regular professional examinations, cleanings, and x-rays (at 3, 4, or 6 month or other intervals depending on your condition). Help us to help you maintain your teeth for your life!

Because we're confident of the durability of our treatments we offer the following limited dental warranties. Failure to have your prescribed in-office professional cleanings, exams, and x-rays will void any and all warranties.

TWO YEAR WARRANTY

Composite (tooth colored) fillings: If composite is our recommended re-treatment we will repair or replace a failed filling at no charge. If the tooth breaks or requires a crown or other treatment, we will credit the cost of the filling toward that treatment.

FIVE YEAR WARRANTY

Crowns, bridges, inlays, onlays, and porcelain veneers: We will replace or repair these at no charge if they chip, break, or come off with normal use.

Please note: These warranties don't include accidents that could also break the normal healthy tooth, or decay resulting from oral hygiene issues. If a night guard is part of your treatment plan, it must be made in our office, worn nightly, and be brought to each visit to maintain a valid warranty. This warranty does not include items not mentioned above such as root canals, over the counter products including night guards, nor does it cover damage to teeth or dental restorations caused by accident, trauma, neglect, or improper use (i.e. biting non-food items such as ice, fingernails, pencils, or similar.)

I, _____ understand the warranty information above.
(Please print name)

_____	_____	_____
Patient/Legal Guardian's signature	**Today's date**	**Relationship to patient**