INNOVATIVE DENTAL HEALTH

Marple Commons, 2002 Sproul Road, Suite 100, Broomall, PA 19008
Telephone: 610-325-1670 | Fax: 610-325-1675 | E-mail: Smiles@innovativedentalhealth.com

Date: __________/__________/__________

Name: ____

Address: ____

Home# _______________________ Cell# _______________________ Work # ______________________

E-mail: ____

Emergency Contact Name & Phone Number: ____

Changes in Dental Insurance? ☐ Y ☐ N if yes, please provide the information below:

Subscriber Name: _____________________________________ Subscriber DOB: ___________________

Name of Ins. Co.______________________________ ID or SSN: ________________________________

Communications Consent Form

I give permission to be contacted in the following manner (check all that apply):

☐ E-Bill (electronic statements). Initial Here: ______________________

☐ E-appointment reminders. Initial Here: ______________________

<u>Medical Update</u>

Note: *There are many drug and medication incompatibilities, some of which may result in dangerous health problems. Information about your current use of drugs and medication is essential.*

*****Any new health conditions that we should be aware of?** ☐Yes ☐No

If yes, please explain:

____

____

Do you need to be pre-medicated prior to dental care? ☐Yes ☐No

Have you ever had an allergic reaction to medication? ☐Yes ☐No

If yes, please check off box.

☐ Aspirin ☐ Codeine ☐ Latex ☐ Penicillin ☐ Sulfa ☐ Iodine ☐ Local Anesthetic

☐ Other: ____

____

1.

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: ___________________________________ Date: ______ / ______ / ______

Health History Reviewed by:

☐ Kim Tran, DMD __________ __________/__________/__________

☐ Elliot Ramer, DMD __________ __________/__________/__________

2.

Patient Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my care).
- Obtaining payment from third party payers (e.g., my insurance company).
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Person completing the form: ______________________________ Signature: __________________________

If other than patient, indicate relationship: _________________ Date: ________/_________/__________

3.

ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Innovative Dental Health Notice of Privacy Practices. By signing below, I am "only" giving acknowledgement that I have received or have had the opportunity to receive the Notice of Privacy Practices.

Patient Signature: ____ Date: ______ / ______ / ______

Financial Policy

- Your portion not covered by insurance, is due at the time of service. You are fully responsible for the timely payments of your account.
- Any quotes of coinsurance given are estimated. You are ultimately responsible for what the insurance company does not pay.

Forms of Payments:

- We accept Cash, Money Order, Cashier's Check, Visa, MasterCard, American Express and Discover Card.
- Care Credit payments are NOT accepted for *Smiles Club Members.*

By signing below, I agree to the following:

- *I will pay my coinsurance/amount due at the time of service.*
- *I will pay a fee of **$25-$75** for missed appointments, unless canceled 48 hours in advance.*
- *I acknowledge that I am responsible for payment in full if my insurance company has not paid the full balance.*
- *I will pay a **$50.00** fee for any returned checks.*
- *I will pay a **$35.00** late fee for balances over 30 days past due.*
- *I will pay all costs of collection, including a **$35.00** collection fee, attorney fees and court costs, should such measures become necessary.*
- *Due to the increasing cost of Personal Protective Equipment (PPE), a $15.00 fee is due at the time of service.*

4.

Innovative Dental Health reserves the legal right to dismiss any patient at any time from our office for such reasons as frequently missing scheduled appointments or for not following suggested dental treatment (non-compliance).

Patient Name: ____ Date: ______ / ______ / ______

Responsible Party Signature: ____ Date: ______ / ______ / ______