Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Address: _____
Street Apartment #

_____
City State Zip Code

Phone (Home): _____ (Cell)_____ (Work): _____ Ext: _____

E-mail Address: _____

Gender: _____ Marital Status: _____

Social Security #: _____ Birth Date: _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ _____
- ☐ _____

• LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: _____
_____

• Do you smoke? ☐ Yes ☐ No

• Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

• Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

• Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____

• Name of Physician: _____ Phone: _____

• Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

How did you hear about our office? Please check one of the following…

☐ Insurance ☐ Drive-By ☐ Internet ☐ Family Member_____

☐ Flyer/Mailer ☐ Website ☐ Social Media ☐ Friend/Co-Worker_____

Spouse or Responsible Party Information

The following is for: ☐ patient ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

AVALON
DENTAL
JEFF PEIFER D.M.D.

Payment Policy and Insurance Policy: Payment is due in full at the time services are rendered. For your convenience, we accept Cash, Care Credit, Debit and Credit cards. We do not offer payment plans. For those of you with dental insurance, our office will be happy to submit claims to your insurance company on your behalf. You understand that you are responsible for all charges for services whether or not paid by insurance. You hereby authorize Avalon Dental to furnish information to insurance carriers concerning your treatment and you hereby assign to the dentist all payments for dental services rendered covered by insurance for services rendered to your or your dependents. You further agree and acknowledge that your signature on this document authorizes your dentist to submit for yourself, spouse, or dependents all insurance claim forms necessary for submission and that you will be bound by this signature as though the undersigned had personally signed the particular claim form. You understand that your insurance is a contract between you, your employer, and the insurance company, Avalon Dental is not a party to that contract. If your insurance company does not pay within 30 days, you will be responsible for the full balance. Co-payments are due at the time services are rendered. You further agree to pay all finance charges, collection costs, attorney's fees, and any other costs that may be incurred to enforce collection of any amount outstanding also acknowledge and understand that if the account is turned over to an attorney for collection, you hereby agree to pay thirty percent (30%) attorney or collection agency fees on the unpaid balance. A service charge of $10 per month will be added to all balances 60 days and older.

Cancellation Policy: Please understand that our appointment times are scheduled to allow us to take care of each individual patient's needs during the patient's visit. Unlike most dental offices, we do not "double book" so if a patient doesn't show up to their appointment, we will have a gap in our schedule until the next patient arrives. Since appointment times at Avalon Dental are in high demand, we value advance notice from our patients who are unable to keep their scheduled appointments, so we may offer that appointment to another patient. We require that any appointment that is no longer needed or is unable to be kept, must be cancelled at least 48 hours in advance of the appointment. Since we certainly understand that illness or other problems can occur (sometimes without any warning), we will not charge you for your first missed or cancelled appointment. In the event a second appointment is missed or cancelled with less than 48 hours notice, or no notice, a $40 charge will be billed. This policy is in effect for all appointments at our office.

Prior express consent for calls/texts/email: By providing the number of my land line, cell phone or other wireless device and my email address now or in the future, I expressly consent and agree that Avalon Dental and any of its affiliates, agents, service providers or assignees may call me using an automatic telephone dialing system or otherwise, leave me a voice, prerecorded, or artificial voice message, or send me a text, e-mail, or other electronic message for any purpose related to appointments, or to the servicing or collection of any account that I may establish with Avalon Dental, or for other informational purposes related to my account, appointment, or treatment ("Communication"). I also agree that Avalon Dental and any of its affiliates, agents, service providers or assignees may include my personal information in a Communication. Avalon Dental will not charge for a Communication, but my service provider may. I agree that Avalon Dental may monitor and record any telephone calls to assure the quality of its service or for other reasons.

Privacy Practice Receipt: This Healthcare Practice recognizes that every patient has the Right of Privacy concerning their personal health information. We make every effort to protect and preserve patient records in a manner that secures this information. By signing this Acknowledgement:You are only confirming that you have received a copy of our PRIVACY PRACTICES. You do not give up any of your Rights and you may choose at some point in the future to provide more specific instructions for us to follow regarding your personal health information.

I have completely read and understand the contents of this agreement. I agree to comply with all policies.

Patient Name:_____

Signature:_____ Date: _____ /_____ /_____

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DENTAL
JEFF PEIFER D.M.D.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PRIVATE HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU MAY ACCESS THIS INFORMATION.

Our Healthcare Practice takes patient privacy matters seriously. We work hard to meet and exceed all existing rules and regulations and will work to keep you informed regarding our office policies and your personal rights regarding privacy.

We are required by federal and state law to maintain the privacy of your health information. We are also required to give you this NOTICE about our privacy practices, our duties, and your right concerning your personal health information. We must follow the privacy practices described in this Notice while it is in effect. This Notice takes effect on April 14, 2003, and will remain in effect until we replace it, at which time we will issue a new Notice to Patients indicating a new activation date. You may request a copy of our Notice at any time, and may request additional copies, as needed by contacting our office.

How We Disclose Health Information

Specialist Referrals: We use and disclose health information about your treatment within our practice, for general healthcare operations, and payment collection. That means your information is available to our immediate staff, and to other practitioners who we may refer you to for additional treatment. This includes, but is not limited to, other healthcare specialists such as surgeons, laboratories and the like. We will exercise our judgment in only distributing the minimum necessary information needed when sending health information to any outside Associates.

General Business Operations: Your information may be reviewed in the course of general healthcare operations for activities such as conducting quality reviews, assessing practitioner performance, evaluation of business costs, conducting training programs, licensing accreditation, and certain certification activities, and other business related evaluations to help us in improving our delivery of healthcare to our patients.

Payment and Collection: Your health information will be sent to third party payers for insurance collection and, when applicable, to collection agencies for assistance in receiving payment for services rendered. Additionally information may be used from time to time as necessary to secure payment for services. We will use our professional judgment and experience with common practice to make decisions on what information to disclose to secure payment.

Family, Friends, Personal Representatives and Others: We may disclose your health information to a family member, friend, or other persons to the extent necessary to help with your healthcare or with payment for your healthcare. You may however request we not disclose to any other than yourself of which we will abide. An example where we might disclose to a family member or friend might be when someone drives you to the practice and we are reporting on progress and time remaining before completion, or where a family member desires to pick up a prescription or x-rays on your behalf. We will use our professional judgment and experience with common practice when disclosing your health information that it is directly relevant to the person's involvement in your healthcare.

We may disclose health information to others who may be involved in your health care and are trying to ascertain your general condition, your current location, or learn of your death.

Marketing Health-Related Services: We will not use your healthcare information for marketing communications without your written authorization. Under federal privacy rules we may send you updated information about our practice or healthcare system, send you information regarding programs and products we offer to further enhance your care and treatment, send reminder notices for appointments, and other small nominal gifts from time to time, such as tooth brushes, which is not considered marketing. We will never provide your name to an outside organization for marketing.

When the Law Requires Us to Disclose: We may disclose your health information to government agencies or others, as required by law. Examples of this include, but are not limited to, law enforcement, required state agency reporting, or coroners seeking to confirm identity. Additionally we disclose to military authorities for purposes such as national security. Abuse and Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or are the victim or possible other crimes. We disclose to the extent necessary to avert further harm to you or others.

PATIENT RIGHTS

Access to Records: You have the right to look at copies of your health information, with limited exceptions. You may request photocopies and copies of x-rays. We will use the format you request, unless we are unable to practically do so. You must make your request to access for health information in writing to our practice. We can provide you with a form to do this, or you may do it by writing a letter specifying exactly what you want to view. If we provide photocopies we will charge you a set amount for each page copied. If you wish to receive x-ray duplicates, we will charge you a set fee per film copied. Check with the office for the current fee schedule. If you request an alternate format we will charge you per the expenses we incur to satisfy your request. You may prefer to ask for a summary rather than receive all of the pages in your file. We can prepare a summary depending on what you are seeking to obtain. The fee for summation will vary depending on time to compile. The hourly rate for summation is also on our current fee schedule. We have up to 30 days (and sometimes longer) to respond, depending on what is required to meet your request. Specifics will be provided upon request.

List of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and a few other activities as specified by law, for the last six years, but not before April 14, 2003. If you request this list more than once in a 12 month period we will charge you a reasonable cost based fee for responding to the additional requests. Fees will be disclosed prior to action being taken.

Restrictions: You have the right to place additional restrictions on our use or disclosure of your health information. We are not required to agree to these restrictions, however, if we do agree, we will abide by our agreement, except in certain emergency situations. If you received this information electronically (via email), you are entitled to receive this in written hard copy form.

Communications to You: You may request we communicate with you about your health information by alternative means or to alternative locations, when you make the request in writing. You must specify the alternative means or location provide satisfactory explanation how payments will be made under the alternative means or location.

Amendment of Your Records: You have the right to request we amend your health information when requesting in writing. We may deny your request however, we will note in your records your request to amend and reason. We cannot delete anything from the formal record but we can add addendum's to the record that may be able to meet your amendment request.