OFFICE POLICES AND HIPAA ACKNOWLEDGEMENTS

It is our desire to make high quality dental care affordable to everyone. The following is a statement of our office policy and financial policy, which we ask that you read, agree to, sign before any treatment is rendered.
My office will gladly submit your insurance claim to your insurance carrier, as a courtesy to you. At the time of treatment, the patient/guarantor is responsible for the portion the insurance does not cover. Please be aware that some insurance companies may not cover all services performed in my office. The patient/guarantor is responsible for all changes that are denied or unpaid by your insurance carrier. If for some unforeseen reason your insurance carrier has not made a payment within 90 days, the patient/guarantor is responsible for these charges.

PAYMENTS

Payments is due at the time of services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, finance charges and any other expense incurred in collecting your account. We accept the following forms of payment: cash, checks, credit cards and financing through third party financing. (Please note: if you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Service Notice.)

A fee of $30.00 will be charged on all returned checks.

I understand my dental insurance is contract between the insurance carrier and the patient, not between doctors and insurance carrier. Please note that NO individual in the office can predict exactly what amount your insurance will pay. When we verify your coverage with your insurance company, they also indicate that there is no guarantee of coverage, until they receive the claim. We will only be able to give you an estimate and we cannot be held responsible to that estimate any way. In some cases, insurance companies use alterative benefits as a method of payment and not pay the total estimated amount. Therefore, do not hold us responsible for payments that a third party may refuse to pay.

Initial _____

MANAGED CARE PLAN

I do not participate in any managed care, HMO, or DMO plans.

INSURANCE SIGNATURE AUTHORIZATION

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me and my dependent and/or other health practitioners relating to all claims for benefits submitted on behalf of myself and/or dependents. I agree and acknowledge that my signature on the document authorizes my dentist to submit claims for benefits, for services rendered, or for services to be rendered, without obtaining my signature on each and every claim submitted for myself and/or dependents. I will be bound by this signature as though I had personally signed each claim. I hereby assign all medical, dental, and/or surgical benefits to which I am entitled for this service to Dr. James P. Toner. A photocopy of this assignment is to be considered as valid as an original.

SCHEDULING APPOINTMENTS

We reserve the doctor and hygienist's time on a schedule for each patient procedure and are diligent about being on time. Because of this courtesy, when a patient cancels an appointment, it affects the overall quality of service, we are able to provide. To maintain the utmost service and care, we do request 2 business days notice to reschedule an appointment. A $50 late fee will be charged for missed appointment.

AUTHORITY OF TREAT

I give Dr. James P. Toner the authority to administer dental x-rays, local injections, anesthetics, and if requested, a tranquilizer in subsequent treatment of my case. If I have a medical condition, that requires premedication, or any drug allergy, I acknowledge that it is my responsibility to inform and remind the Doctor, Assistant, or the Hygienist every time before treatment. Please advise my office of ANY and ALL medications you may be taking – especially any blood thinners (Aspirin on a daily basis or Coumadin).

PATIENT COMMUNICATION

Voice Messages: I understand brief messages from Dr. James P. Toner may be left on my home answering phone or with anyone who answers the telephone at my home unless I have provided Dr. James P. Toner with alternate instructions for communication.

☐ I **AGREE** ☐ **I DO NOT AGREE**

Email: Except for appointment reminders, we use secure methods to electronically communicate with our patients. **Unencrypted email is not a secure form of communication**. There is some risk that individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties.

Our emails to you that include identifiable health information or other sensitive or confidential information will require you to input a passcode to verity your identity to open the email.
Please select your email preference. Choose One:

☐ I prefer to receive information via Dr. James P. Toner's secure encrypted communication methods with passcode protection to verify my identity. I consent to receiving appointment reminders via unencrypted email. I understand the minimum necessary information necessary is used in these reminders. I understand I can withdraw my consent at any time.

☐ I do not consent to receiving any information via email. I Understand I may change my mind and provided consent later.

CELL PHONE

I consent to the office of Dr. James P. Toner, using my cell phone number to contact me regarding appointments and to call regarding treatment, insurance and my account in the means indicated below. I understand that I can withdraw my consent at any time.

☐ CALL ☐ TEXT ☐ BOTH ☐ NONE

I,_____[full name], grant the right to Dr. James P. Toner to release my dental history and other information about my dental treatment to third party payors, and/or other health care professional and may be disclosed for treatment, payment or healthcare operations.

☐ I AGREE **☐ I DO NOT AGREE**

In the space below, list any **family members or other persons** we **CAN** share information with:

Name _____ Relation _____ Phone Number _____

Name _____ Relation _____ Phone Number _____

I have read, understand, and agree to above Office Policies and HIPAA Acknowledgements.

_____ _____

Print Name Signature (Parent or Legal Guardian if patient is a minor)

_____ _____

Date Email Address

Patient, Pharmacy, and Insurance Information

PATIENT INFORMATION

First Name Middle Last Name Date of Birth Social Security

Street City State Zip Code

Preferred Phone Number _____ Is this a mobile number? ☐ YES ☐ NO

Email Address _____

Emergency Contact _____ Relation _____ Phone _____

Primary Language ☐ English ☐ Spanish ☐ Other _____

RESPONSIBLE PARTY

First Name Middle Last Name

Date of Birth _____ Relation _____

Responsible Party Signature _____ Date _____

Preferred Pharmacy

Name Phone Number

Street City State Zip Code

Primary Dental Insurance

Is the subscriber the same as the patient? ☐ YES ☐ NO

Subscriber Information

First Name Middle Last Name Date of Birth

Employer Name _____ Insurance Company _____

Subscriber ID/Policy Number _____ Group/Contact Number _____

Patient Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Disabled Dependent ☐ Other Dependent

Subscriber SSN _____

Secondary Dental Insurance

Is the subscriber the same as the patient? ☐ YES ☐ NO

Subscriber Information

First Name Middle Last Name Date of Birth

Employer Name _____ Insurance Company _____

Subscriber ID/Policy Number _____ Group/Contact Number _____

Patient Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Disabled Dependent ☐ Other Dependent

Subscriber SSN _____

Health History

Reason for Visit ☐Check-up | ☐Broken Tooth | ☐Tooth Pain | ☐Cosmetic | ☐Dentures | ☐Other _____

Are you under the care of a primary physician? ☐ Yes ☐No

Primary Physician's Name_____ Physician's Phone Number _____

Date of Last Visit _____

☐I don't know | ☐Last 6 months - 1 year | ☐1-3 Years | ☐Greater than 4 years | ☐Never | ☐Other _____

Are you taking or have you taken any steroid/cortisone therapy in the last 2 years? ☐ NO ☐ YES

Have you ever been hospitalized? ☐ NO ☐ YES

Are you taking or have you taken Oral Bisphosphonate (e.g., FOSAMAX, BONIVA) or IV Bisphosphonates, (e.g., ZOMETA, AREDIA)? ☐ NO ☐ YES How Long? _____

Do you require antibiotics prior to dental procedures? ☐ NO ☐ YES Type: _____

Are you allergic or have you had an adverse reaction to any of the following?

☐ **NONE**

☐ Amoxicillin | ☐ Aspirin | ☐ Codeine | ☐ Epinephrine | ☐ Latex | ☐ Metals | ☐ Novocain | ☐ Penicillin

☐ Sulfa | ☐Tetracycline |☐Other _____

List any medications you are taking including non-prescription drugs and herbal/vitamins

☐ **NONE**

_____

_____

Check any conditions that apply to you

☐ **NONE**
☐ Alcoholism
☐ Allergies or Hives
☐ Anemia
☐ Arthritis
☐ Artificial Joint/Pins
Type _____
Age _____
☐ Aspirin Therapy
☐ Asthma
☐ Blood Thinner
☐ Blood Transfusion
☐ Breathing Problems
☐ Cancer
Type _____
☐ Chemotherapy
☐ Coumadin Therapy
☐ Dementia
☐ Diabetes
Type _____
☐ Dialysis
☐ Drug Addiction
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting/Dizziness
☐ Hearing Impairment
☐ Heart Murmur
☐ Heart Surgery
Date _____
☐ Heart Trouble
Type _____
☐ Hepatitis
Type _____
☐ High Blood Pressure
☐ HIV
☐ Kidney Disease
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease/COPD
☐ Lupus
☐ Mitral Valve Prolapse
☐ Mobility Impairment
☐ NON-Dental Implants
Type _____
☐ Organ Transplants
Type _____
☐ Pacemaker
☐ Psychiatric Care
☐ Radiation Therapy
☐ Radiosurgery
☐ Rheumatic Fever
☐ Seizures
☐ Sexual Transmitted Disease
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis (TB)
☐ Ulcers
☐ Visual Impairment
☐ Other Disease/Illness
Type _____
_____

Dental History

Date of Last Dental Visit

☐ I don't know | ☐ Last 6 mth | ☐ 6 mth- 1 year | ☐ 1-3 years | ☐ Greater than 4 years | ☐ Never | ☐ Other _____

Date of Last Dental X-rays

☐ I don't know | ☐ Last 6 mth | ☐ 6 mth- 1 year | ☐ 1-3 years | ☐ Greater than 4 years | ☐ Never | ☐ Other _____

Women Patients Only

Are you currently pregnant? ☐ Yes ☐ No Estimated Delivery Date _____

Are you Nursing? ☐ Yes ☐ No Are you taking any birth control prescription? ☐ Yes ☐ No

**Note Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to perform an examination and diagnose my condition. I also give my consent for any preventive or basic restorative procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Patient's Signature_____ Date _____

Dr's Signature/Medical History Review_____ Date _____

6 MONTHS UPDATE

Patient's Signature_____ Date _____

Dr's Signature/Medical History Review_____ Date _____