CONTACT INFORMATION

Name:_____ Prefer to be called:_____ ☐ Male ☐ Female

Address:_____ City:_____

State:_____ Zip:_____ Cellphone:_____ Home Phone:_____

Email:_____ DOB:_____

Driver's License:_____ SSN:_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Other ☐ Minor

Contact preference: ☐ Call ☐ Text ☐ E-mail

Emergency Contact:_____ Phone:_____

Relationship to patient:_____

Person financially responsible for this account? _____ Relationship:_____

Whom may we thank for referring you to our office? _____

INSURANCE AND FINANCIAL POLICY

At Piatt Park Dental, we believe that you deserve the best care. That's why we always present you with the best dental solutions possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits, but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

Initial

_____ Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.

_____ We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you the exact out of pocket figures you may require.

_____ We will bill your insurance as a courtesy. If insurance does not pay within 90 days, Piatt Park Dental reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

_____ Today's Dental does require payment in full for your portion at the time of service. We accept MasterCard, Visa, American Express, Discover, cash, and checks (for existing patients with established payment history). We do not accept checks for over $500.00 for any patient. If you are in need of an extended finance option, we also work with CareCredit, who offers 3, 6, 12 or 18 month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit.

_____ A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hour notice to avoid a $35/hour cancellation fee (emergencies are an exception).

_____ In the event of an emergency after regular business hours a $55 emergency fee will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged $125 after hours emergency fee.

I agree with the above conditions.

Print Name:_____ Date: _____

Patient/Parent Signature: _____

INSURANCE INFORMATION

Name of Insured:_____

DOB:_____ Relationship to Patient:_____

Dental Insurance Co.:_____ Group #:_____ ID#/SSN:_____

Employer:_____ Occupation:_____

Secondary Coverage? ☐ Yes ☐ No

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Alexandra Wenzel DDS LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions. I understand that proper diagnosis can only come after an examination is done and radiographs are taken. I hereby authorize Dr. Wenzel to perform any necessary examination and radiographs needed for proper diagnosis.

Responsible Party Signature:_____ Date:_____

Relationship:_____

MEDICAL AND DENTAL HISTORY

Medical History

Please mark (Y) for “yes”, or (N) for “no” for any of the following which may apply to you now, or in the past:

Y N Heart Attack or Heart Trouble
Y N Congenital Heart Disease
Y N Chest Pain with exercise (angina)
Y N High Blood Pressure
Y N Heart Valve Disorder
Y N Pacemaker
Y N Psychiatric Disorders
Y N Implant or Artificial Joint
When? _____
Y N Anemia or Blood Disorder
Y N Excessive Bleeding
Y N Diabetes
Y N Stroke
Y N Use Tobacco?

Y N Thyroid Disease
Y N Asthma
Y N Ulcers, Reflux, Heartburn
Y N Digestive Disorders
Y N Kidney Problems
Y N Fainting or Blackouts
Y N Drug/Alcohol Dependency
Y N Headaches or Migraines
Y N Epilepsy or Seizures
Y N Tumors, Cancer, Radiation
Y N Tuberculosis, Lung Problems
Y N Hepatitis A B C D
Y N AIDS or HIV Infection

Periodontal disease has been linked to the following, do you have any family history of:
(circle any that apply)

Heart Disease Stroke Diabetes Early-Term Birth Alzheimer’s

Are you currently pregnant?_____ If yes, when are you expecting?_____

Have you been hospitalized in the last two years (including pregnancy)? Y N
If yes, please explain _____

Physician's name and phone:_____

Have you ever had an allergic reaction to an anesthetic or drug such as penicillin, sedative, latex, aspirin, or metals? Y N

If yes, please explain _____

Please list any prescription or over the counter drugs, medications, or vitamins you are currently taking:

_____

_____

_____

_____

_____

_____

Dental History

Reason for today's visit?_____ Last dental visit? _____

Have you ever had any serious problems with previous dental treatment?

_____

Please rate your smile: 1 2 3 4 5 6 7 8 9 10 (best)

Please rate the color of your teeth: 1 2 3 4 5 6 7 8 9 10 (best)

Responsible Party Signature:_____ Date:_____

Doctor/Hygienist Signature:_____ Date:_____

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please read it carefully. The privacy of your health information is important to us.

Our Legal Duty

We are required by applicable 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 legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or 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 the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice.)

Disclosure Accounting: 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 certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, You may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name _____ Date _____

Signature _____

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

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specify)