Dean Dental

7736 Madison Blvd. Suite #2

Huntsville, AL 35806

Financial Policy

Thank you for selecting us as your personal dental care team. To promote a long-term, mutually satisfying relationship, we would like to explain our office policy regarding treatment, insurance, appointments and fees. Please read this carefully and ask any questions or bring up concerns before treatment is rendered.

Treatment: We will always recommend treatment base on optimal care, and not on insurances benefits. Insurance companies exist only to make money and do not always have your best interest in mind. We will however, always offer alternate treatment options that may better fit your health care budget.

Insurance: As a courtesy to you, we will submit all insurance claims on your behalf, and any follow-up processes that may be necessary. Our staff prides itself on helping our patients maximize their benefits, and is always available for questions. Ultimately the patient is fully responsible for the charges for the treatment rendered. Your Insurance may not cover the services or may only partially cover them and any estimate given by this office is considered a guideline until insurance payment is received and the patient's account is reconciled. The office makes no guarantee of the actual payment by your insurance company. At no time will we change treatment codes or dates of service to manipulate your insurance benefits. This is insurance fraud.

Missed Appointments: When we schedule your appointment, this time is reserved exclusively for you. When you fail to notify us of your inability to keep the appointment, another patient in need of dentistry is unable to receive treatment. We request that you give us 24 hours' notice when you realize you cannot keep an appointment. A fee of $50.00 per hour scheduled may be charged for broken day of appointments.

Payment at time of service: We accept cash, personal checks, MasterCard, Visa, Discover, and ATM cards. In addition, we offer Care Credit for those requiring extended payment plans. We will collect any deductible or estimated co-pay at time of service.

Returned Checks: Will result in a $35 fee charged to your account. Cash or credit card must be used to pay remaining bill.

I understand that I am responsible for all fees incurred for dental treatment and agree to pay according to the option I have chosen. **Any account balance over 60 days will incur a 1.5% finance charge. Additional charges may occur if the account is turned over for collection.**

Signature: ________________________________ Date: ________________

(Patient/Parent/Legal Guardian)

Date ______________________

GETTING TO KNOW YOU AS OUR PATIENT

PATIENT NAME	**SOCIAL SECURITY NUMBER**	**HOME PHONE** ( )
Home Address	City, State, Zip	Birthdate / /
Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Separated	❑ M ❑ F	Drivers License and State

Primary Insurance Company ______________________ Group______________ Subscriber______________

Secondary Insurance Company ______________________ Group______________ Subscriber______________

Responsible Party

NAME	SOCIAL SECURITY NUMBER	HOME PHONE ( )
Home Address	City, State, Zip	Birthdate / /
Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Separated	Relationship to Patient	Drivers License and State
Responsible Person's Employer	Occupation	Work Phone ( )
Business Address	City	State Zip
Spouse's Name	Social Security Number	Birthdate / /
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone ( )
Spouse's Business Address	City	State Zip

How did you hear about our Office?

(check only one)

Who selected this Office? ❑ Self ❑ Spouse ❑ Parent ❑ Employer

Where did you find the Phone Number to this Office? ______________________

❑ Referred by a friend ❑ Yellow Pages ❑ Relative ❑ Insurance Plan ❑ Welcome Wagon

❑ Other______________ ❑ TV/Radio Ad ❑ Newspaper Ad ❑ Direct Mailing ❑ Sign by Building

If you were referred, whom may we thank for referring you? ______________________

CONSENT

•I will answer all health questions to the best of my knowledge __________
Initial

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Signature Date Relationship to Patient

TERMS AND CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment.
As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time the services are performed.
I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this Office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. 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 and agree to their content.

Signed______________________________________ **Date**______________

There may be a charge for any missed appointments or appointments not cancelled 48 hours before the appointment time.

PATIENTS DENTAL HEALTH

Why have you come in to see us today? (e.g.: pain, checkup, etc.)__________

Previous Dentist__________ Last Visit__________ Date of last cleaning__________

Reasons for changing dentists:__________

What problems have you had with past dental treatment?__________

Are you nervous about seeing a dentist? ❑ Yes! ❑ No If yes, please tell us why:__________

How often do you brush?__________ Do you floss? ❑ Yes ❑ No How often?__________

(please circle each)

Y N I clench or grind my teeth during the day or while sleeping.
Y N My gums bleed while brushing or flossing.
Y N I like my smile.
Y N I prefer tooth-colored fillings.
Y N I avoid brushing part of my mouth due to pain.
Y N My gums feel tender or swollen
Y N I have problems eating.
Y N I have had orthodontics.
Y N I have had a facial or jaw injury.
Y N I want my teeth straight.
Y N I want my teeth whiter.

What are your dental priorities?__________
(e.g.: apprentice, dental health, financial considerations, etc.)

PATIENTS MEDICAL HISTORY

I consider my health to be *(please check one)* ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you or have you had any of the following? *please circle Y for yes or N for no.*

Doctor Notes Only:

1. Y N Heart Disease
2. Y N Heart Murmur/Mitral Valve Prolapse
3 .Y N Stroke
4. Y N Congenital Heart Lesions
5. Y N Rheumatic Fever
6. Y N Abnormal Blood Pressure
7. Y N Anemia
8. Y N Prolonged Bleeding Disorder
9. Y N Tuberculosis or Lung Disease
10. Y N Asthma
11. Y N Hay Fever
12. Y N Sinus Trouble
13. Y N Epilepsy/Seizures
14. Y N Ulcers
15. Y N Implants/Artificial Joints: ❑ Hip ❑ Knee ❑ Other
16. Y N I smoke or use tobacco. If yes, how much per day?______ How many years?______
17. Y N I have consumed alcohol within the last 24 hours.
18. Y N I usually take an antibiotic prior to dental treatment.
19. Y N Have you ever taken Fen-Phen or Redux?
20. Y N I have had major surgery: Year______ Type of operation:__________ Year______ Type of operation:__________
22. Y N Liver Disease
23. Y N Jaundice
24. Y N Hepatitis Type____.
25. Y N Diabetes
26. Y N Excessive Urination and/or Thirst
27. Y N Infectious Mononucleosis (Mono)
28. Y N Herpes
29. Y N Arthritis
30. Y N Sexually Transmitted/Venereal Disease
31. Y N Kidney Disease
32. Y N Tumor or Malignancy
33. Y N Cancer/Chemotherapy
34. Y N Radiation Treatment
35. Y N History of Drug Addiction
36. Y N AIDS
37. Y N Immune Suppressed Disorder
38. Y N Hearing Loss
39. Y N Fainting Spells
40. Y N Glaucoma
41. Y N History of Emotional or Nervous Disorders

WOMEN

42. Y N Are you taking birth control medication?
43. Y N Are you or could you be pregnant or nursing?

21. Y N Do you have any other medical problem or medical history NOT listed on this form?__________

Are you allergic to any of the following?
Please circle Y for yes or N for no

44. Y N Aspirin
45. Y N Ibuprofen
46. Y N Sulfa Drugs/Sulfites/Sulfides
47. Y N Penicillin
48. Y N Codeine
49. Y N Latex, Metals, Plastics
50. Y N Local Anesthetics (Novocaine)
51. Y N Other Medications - Which ones?__________

Please list all medications you are currently taking:

Medicine__________ Condition__________

Medicine__________ Condition__________

Medicine__________ Condition__________

Medicine__________ Condition__________

Physician's Name__________ Phone__________

Address__________ Fax__________

In the event of an emergency please contact:

Name__________ Relationship__________ Phone__________

Name__________ Relationship__________ Phone__________

Initial medical/dental health reviewed by:

X__________ / ____/____ X__________ / ____/____
Doctor's Signature Date Patient's Signature Date

Periodic medical/dental health reviewed by:

X__________ / ____/____ X__________ / ____/____
Doctor's Signature Date If patient is a minor: Parent/Guardian's Signature Date

GETTING TO KNOW YOU AS OUR PATIENT