Bloomfield Hills dental associates

Financial and Appointment Scheduling Policies

Thank you for selecting us as your dental health provider. It is our goal to provide you and your family with the highest quality of dental care, while maintaining a friendly and relaxing environment. In order to keep our standard of care to a level that best serves your dental needs, we ask you to please observe the following guidelines.

Financial Policy:

It is important that you realize that our professional services are rendered to you and charged to you. Our fees for service are the same for all patients whether or not they have dental insurance. We require payment at the time service is rendered. For your convenience we accept MASTERCARD, VISA, DISCOVER and AMERICAN EXPRESS as well as cash, personal checks or money orders. Additionally, if you require financing for procedures, we offer CARE CREDIT through a third party financing company.

We participate in most insurance plans and do our best to collect all the benefits you are entitled to however, due to deductibles, maximums and excluded services there will usually be a co-payment due.

- Using the information provided by your insurance carrier and the doctors treatment plan for you we will estimate the insurance benefit and any co-payment prior to treatment.
- As each part of your treatment is scheduled you will be informed of the amount due. We require payment the day of treatment.
- After the treatment is completed we will fill out the necessary paperwork and supply the necessary radiographs and documentation with a request for payment to your insurance carrier.
- After we receive their reply we will either refund any overpayment to you or bill you for the unpaid balance.

Appointment Scheduling Policy:

We strive to create a patient experience that focuses on you and your health in an ideal patient focused atmosphere. Your experience in our office matters deeply to us and we take great pride in taking care of your dental health needs. This commitment to service requires a bond of trust between us that you will be at your reserved appointment time and in return we will be prepared for you. We respect your time and make every effort to offer appointments that fit into your schedule. We also understand the importance of your time and always strive to remain on schedule. If we are significantly delayed due to an unforeseen emergency every effort will be made to contact you. Appointments are reserved exclusively for you and we require you arrive at your reserved appointment on time. We require **48 hours notice** to change a reserved appointment. Failure to give the proper notice will result in a **$50 cancellation fee in our office.** This amount will be billed directly to your account and is due in full prior to your next scheduled appointment.

By signing this document you acknowledge our Financial and Appointment Scheduling Policies.

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature:_____ Date:_____

Additional Family Members:_____

Bloomfield Hills Dental Associates
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PATIENT INFORMATION

Date_____

Social Security # _____

Patient Name_____

Last Name_____

First Name_____ Middle Initial ___

Address_____

Email_____

City_____

State_____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate_____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Patient Employer/School_____

Occupation _____

Spouse's Information:

Spouse's Name_____

Birthdate _____

Social Security # _____

Employer_____

Whom may we thank for referring you? _____

_____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate_____Social Security # _____

Relationship to Patient_____

Insurance Co. _____

Group #

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to
Name of Insurance Company(ies)

Dr. _____ 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 authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, parent, Guardian or Personal Representative

_____
Please print name of patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Cell (_____) _____ Work (_____) _____ Ext._____ Home (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name_____ Relationship _____

Phone (_____) _____ Alternate Phone (_____) _____

DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist_____

City/State_____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐Yes	☐No
Bleeding gums	☐Yes	☐No
Blisters on lips or mouth	☐Yes	☐No
Burning sensation on tongue	☐Yes	☐No
Chew on one side of mouth	☐Yes	☐No
Cigarette, pipe, or cigar smoking	☐Yes	☐No
Clicking or popping jaw	☐Yes	☐No
Dry mouth	☐Yes	☐No
Fingernail biting	☐Yes	☐No
Food collection between teeth	☐Yes	☐No
Foreign objects	☐Yes	☐No
Grinding teeth	☐Yes	☐No
Gums swollen or tender	☐Yes	☐No
Jaw pain or tiredness	☐Yes	☐No
Lip or cheek biting	☐Yes	☐No
Loose teeth or broken fillings	☐Yes	☐No
Mouth breathing	☐Yes	☐No
Mouth pain, brushing	☐Yes	☐No
Orthodontic treatment	☐Yes	☐No
Pain around ear	☐Yes	☐No
Periodontal treatment	☐Yes	☐No
Sensitivity to cold	☐Yes	☐No
Sensitivity to heat	☐Yes	☐No
Sensitivity sweets	☐Yes	☐No
Sensitivity when biting	☐Yes	☐No
Sores or growths in your mouth	☐Yes	☐No

How often to you floss?_____

How often do you brush?_____

- O V E R -

HEALTH HISTORY

Physician's Name (PCP) _____ Date of last visit_____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis Type _____	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
		High Blood Pressure	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No		
Cortisone Treatments	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No		
Do you wear contact lenses?	☐ Yes ☐ No				

Women:

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name _____

Phone (_____)_____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____

SIGNATURE

Patient's Signature_____ Date _____

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and discolsed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare options.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email or send a text to you to confirm appointments?	YES	NO
May we leave a message on your voicemail	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature:_____ Date:_____

Witness: _____ Date:_____

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