Welcome to Our Office

Patient Name: _____

Gender: Male / Female Birth Date: _____

SS/ID#: _____

Address: _____

City: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Employer: _____

How did you hear about us? _____

INSURANCE INFORMATION

If you are the subscriber, skip this section.

Name of Primary Subscriber: _____

Primary Subscriber Birth Date: _____ Gender: Male / Female

Address (if different from above): _____

_____

Relationship to Patient: _____

Insured's Employer: _____ Plan Name: _____

Subscribers SS/ID#: _____ Group #: _____

IS THERE SECONDARY INSURANCE COVERAGE? YES / NO

Please specifiy secondary insurance with our New Patient Coordinator.

WHAT IS YOUR PREFERRED METHOD OF CONTACT?

☐ Home ☐ Cell Phone/Text ☐ Work Phone ☐ Email ☐ Other:

May we contact you at work? Yes / No

MEDICAL HISTORY

Are you under care of a physician: Yes / No

If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes / No

If yes, please explain: _____

Are you taking any medications? Yes / No

If yes, please explain or provide medication list if applicable: _____

_____

_____

Have you ever taken Fosamax, Boniva, Actonel or any ther medications containing bisphosphonates? Yes / No

Do you use tobacco? Yes / No

WOMEN

Pregnant/Trying to get pregnant? Yes / No

Are you nursing? Yes / No

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Local Anesthetics ☐ Sulfa Drugs

If yes, please explain: _____

DO YOU HAVE, OR HAVE YOU HAD ANY, OF THE FOLLOWING?

☐ AIDS/HIV Positive	☐ Heart/Pacemaker	☐ Radiation
☐ Diabetes	☐ High Blood Pressure	☐ Tonsillitis
☐ Fainting/Dizziness	☐ Pain in Jaw Joints	☐ Chemoherapy
☐ Hepatitis A, B, or C	☐ Swelling of Limbs	☐ Cortisone Medicine
☐ Osteoporosis	☐ Cancer	☐ Hemophilia
☐ Stroke	☐ Excessive Bleeding	☐ Leukemia
☐ Artificial Joint	☐ Heart Disease	☐ Sickle Cell Disease
☐ Epilepsy or Seizures	☐ Hypoglycemia	☐ Tumors or Growths

Print Name: _____

Signature of patient, parent, or guardian: _____ Date: _____

Information Sharing Consent Form

I, _____ , give my permission to share information concerning:

- ☐ My dental teatment
- ☐ The cost and financial arrangements for my dental treatment
- ☐ My personal health information
- ☐ Other: _____

I give my permission to share the above noted information with:

- ☐ Insurance
- ☐ My spouse (name): _____
- ☐ My parent(s) (names): _____
- ☐ My child or children (names): _____
- ☐ Other: _____

I, _____ , DO NOT give my permission to share ANY information regarding my treatment, financial arrangements or personal health information with the exception of what is outlined in the Harrison Dental HIPAA policy.

Initial: _____

Print Name: _____

Signature of patient, parent, or guardian: _____ Date: _____

Consent for Services

Thank you for choosing us as your Dental Care Provider. We look forward to and are committed to providing you excellent dental care.

Patients are responsible for full payment of account.
Deductibles, co-payments, and/or payment in full are due at time of service.
If you have no insurace, payment is due at time of service.

Patients who carry insurance should remember that services are rendered and charged to the patient, **NOT** the insurance company.

It is the Patient's responsibilty to provide accurate insurance information to the office **and know what benefits are provided by their insurance company**. We will be happy to file an insurance claim for you, but please realize we cannot accept the responsibilty for collecting on a claim or negotiating a disputed claim.

- If your insurance company does not pay their portion within 30 days, that balance becomes your responsbility and your account must be paid in full at that time.
- We offer a 5% discount for: Senior Citizens OR Cash/check payments

Outside financing is available. Please ask us in advance, prior to your appointment for information and help.

I hearby agree to the above terms and authorize my insurance benefits to be paid directly to Harrison Dental. **I understand that I am financially responsible for non-covered services**. I also authorize Harrison Dental to release any information required to process insurance claims.

☐ I have read the above conditions of treatments and payments and agree to their content

Print Name: _____

Signature of patient, parent, or guardian: _____ Date: _____

Patient Photo Release Form

I, _____ , hearby authorize Harrison Dental, or any of their assignees to take photographs, slides, and videos of my teeth, jaws, and face. I understand that the photographs, slides, and videos will be used as a record of my care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, Facebook posts, Instagram, etc). I further understand that if the photographs, slides, and videos are used in any publication or as part of demonstration, no personal identifying information will be shared. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing. If declining this consent, leave blank.

Please initial:

_____I do not mind if my photographs are used in any of the above stated sistuations

_____I DO NOT give my permission to share ANY photographs

Print Name: _____

Signature of patient, parent, or guardian: _____ Date: _____

Harrison Dental Financial Policy

We, the staff of Harrison Dental thank you for choosing us as your dental provider. We consider it a privledge to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibilty is vital to that provider-patient relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time, you have any questions or concerns regarding our fees, policies or responsibiities please feel free to ask.

In order to keep our costs reasonable we require payment **at the time of service**, including any deducatibles and estimated co-payments, unless our staff has approved payment arrangements **in advance**. We make payment as convenient as possible by accepting:

- Credit Cards
- In-state Checks
- Money Orders
- Care Credit
- Cash

A $35.00 service fee will be chargeed for all returned checks. You may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

INSURANCE

Please remember that your insurance policy is a contract between you and your insurance carrier. As a courtesy to our patients, we will file your insurance claim for

you. We have found that insurance carriers will request needless and redundant information from a provider of services. Any requests for additional items will gladly be accomodated.

Please be aware the out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions or reductions such as resonable and customary or usual and prevailing. Our fees are well within such ranges and although we assist in the filing of an appeal if these limitations are imposed, the guarantor is responsible for **all out-of-network fees**. If we are not contracted with your carrier, we will not negotiate reduced fees with your carrier.

TREATMENT GUARANTEES

As long as patients care for their teeth and maintain regular checkups, we guarantee our work. If you do not follow through with your care, we cannot be responsible for any new decay or breakdown of tooth structure.

Special Implant Consideration: If an implant fails and cannot be replaced elsewhere in the mouth, despite regular maintenance and care, they will be reimbursed at the rate of 50%. ***THERE ARE NO GUARANTEES FOR SMOKERS.**

DISCOUNTS

As a courtesy to our patients, we offer a Senior Discount (65+) and a Cash Courtesy that applies to checks and cash, not Debit or Credit cards. Only one discount may be used at a time, **there is no doubling of courtesy discounts**, including discounts through the Harrison Dental Plan.

MISSED APPOINTMENTS

We require notice of cancellations 48 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without

notifying us in advance, a missed appointment fee will apply. These fees are typically $25 per hour for hygeine appointment, and $50 per hour for a doctor appointment. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

TIMELINESS OF APPOINTMENTS

We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule if necessary. If you arrive late for an appointment, we may need to reschedule that in respect for other scheduled pateients.

We realize the temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

I have read and understand the above financial policy. I agree to assign insurance benefits to Harrison Dental whenever applicable. I also agree, in addition to the amount I owed, I will be responsible for the fee charged by the collection agenct, as well as any Court fees, for costs of collections if such action should become necessary.

Print Name: _____

Signature of patient, parent, or guardian: _____ Date: _____