

Welcome!

JOHN A. SINES JR., DDS
Family and Cosmetic Dentistry
—Patient Account Information—

PATIENT NAME _____
Last First Middle Marital Status (S-M-D-W)

Do you prefer to go by a different first name? _____

SOCIAL SECURITY# _____ - _____ - _____ **DATE OF BIRTH** _____

HOME ADDRESS _____

MAILING ADDRESS _____
IF DIFFERENT FROM HOME ADDRESS

CITY _____ **STATE** _____ **ZIP CODE** _____

HOME PHONE _____ **WORK PHONE** _____

CELL PHONE _____ **E-mail** _____

EMPLOYER _____ **OCCUPATION** _____

Emergency Contact _____ Phone _____ Relationship _____

Referred by: ___ Drive-by ___ Yellow Pages ___ Insurance Co. ___ Patient: _____

IF PATIENT IS A MINOR

PATIENT LIVES WITH: ___ both parents ___ Mother ___ Father ___ Grandparent ___ other _____

LEGAL GUARDIAN _____
Last First Middle Marital Status (S-M-D-W)

PRIMARY DENTAL INSURANCE COVERAGE

-MUST HAVE COPY OF INSURANCE CARD-

INSURED NAME _____ **RELATIONSHIP TO PATIENT** _____

INSURED ADDRESS (if different from patient) _____

SOCIAL SECURITY # _____ - _____ - _____ **DATE OF BIRTH** _____

EMPLOYER _____ **GROUP NUMBER** _____

INSURANCE COMPANY _____

OUR OFFICE DOES NOT TAKE ASSIGNMENT FOR SECONDARY OR MEDICAL INSURANCE

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I here by authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. To the extent permitted by law, I consent to your use and disclosure of my PHI (protected health information) to carry out payment activities in connection with my claims.

SIGNATURE _____ **DATE** _____
Patient (Parent or Guardian if Patient is a Minor)

Welcome!

PATIENT MEDICAL / DENTAL HISTORY

NAME: _____ M / F DOB: _____

Are you now or recently been under a physician's care? YES / NO Explain: _____

Are you taking any medication? YES* / NO Physician Name: _____ Phone # _____

Have you ever taken BISPHOSPHONATES? (Fosamax, Actonel, Boniva, Reclase, etc.) YES* / NO Are you on a Blood Thinner? YES* / NO

Do you smoke, chew, use snuff or any other forms of tobacco? YES* / NO Do you use recreational drugs or controlled substances? YES* / NO

*List Meds or Explain "YES" responses _____

ALLERGIES to medications:

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Dental Anesthetics	<input type="checkbox"/> Metals	<input type="checkbox"/> Sulfa Drugs
<input type="checkbox"/> Bleach	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Tetracycline
<input type="checkbox"/> Codeine	<input type="checkbox"/> Latex	<input type="checkbox"/> Other: _____	

MEDICAL HISTORY:

<input type="checkbox"/> Abnormal Bleeding	<input type="checkbox"/> Radiation/Chemo therapy	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Seizures
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cold sores/Fever Blisters	<input type="checkbox"/> *Heart Attack	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Shingles
<input type="checkbox"/> Angina	<input type="checkbox"/> Congenital Heart Defect	<input type="checkbox"/> *Heart Surgery	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Diabetes	<input type="checkbox"/> *Artificial Hrt Valve	<input type="checkbox"/> *Joint Replacement	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> *Stent	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> *Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> *Pace Maker	<input type="checkbox"/> Lupus	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> *Mitral Valve Prolapse	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> *Rheumatic Fever	<input type="checkbox"/> Ulcers

Please explain if you have had any of the above marked with *, or any condition or problems not listed above:

Females: Could you be pregnant? YES / NO Are you pregnant? YES / NO If yes: due date _____ Are you nursing? YES / NO

DENTAL HISTORY:

When was your last cleaning and exam? _____ Do you pre-med before dental visits? YES / NO

Have you had a full mouth or Panorex dental x-ray taken in the past three (3) years YES* / NO *if yes, please have copy emailed or mailed to our office

Previous Dental Provider: _____ Phone # _____ Do you like your smile? YES / NO

<input type="checkbox"/> Gums bleed	<input type="checkbox"/> Clench / grind teeth	<input type="checkbox"/> Orthodontic work	<input type="checkbox"/> Loose teeth
<input type="checkbox"/> Jaw pops / clicks	<input type="checkbox"/> Removable partial / denture	<input type="checkbox"/> Missing teeth	<input type="checkbox"/> Sensitive (circle below)
<input type="checkbox"/> Bad breath	<input type="checkbox"/> Food caught between teeth	<input type="checkbox"/> Broken teeth / chipped	HOT COLD SWEETS PRESSURE

Have you ever been told you have gum disease? YES / NO If yes, have you had treatment for it? YES / NO

Purpose for initial visit today: _____

HEALTH INFORMATION PRIVACY ACT (HIPAA)

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. I will be contacted in the following manner to verify appointments or to discuss billing/account information: Home telephone (leaving a detailed message when unavailable), Work telephone (leaving name & number ONLY when unavailable) or by written communication to my home address. Sending information by Fax to my home or office, or mailing information to my office will be done ONLY at my request. The HIPAA information is posted at the office and I have have a copy on request.

I understand I am responsible for my account regardless of my insurance. I also understand that my insurance is an agreement between me and my insurance company. I give permission for Dr. John A. Sines, Jr., and clinical team to take any necessary diagnostic films and photographs to make a complete diagnosis of my dental needs.

I have read, agree to, and understand the statements listed above.

SIGNATURE _____ DATE _____

Patient (Parent or Guardian if Patient is a Minor)

FINANCIAL ARRANGEMENTS

We are committed to providing you with the best possible care. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

1. Payment is required at time that services are rendered.
2. We accept cash, checks, and all major credit cards and CareCredit. There is a returned check charge of \$30.00.
3. CareCredit is subject to approval and is available for 3-mo/no interest for credit over \$300 or you can chose to have your payments spread out over five years for credit over \$1000 with a special interest rate. More information is available in the CareCredit brochure at the front desk.
4. Concerning divorced or separated parents: the parent that brings the child or children in for treatment is responsible for payment that day.

X _____
Initials

We reserve time for your appointment.

Broken appointments or appointments cancelled without 24 hours notice will be charged \$35.00.

CONCERNING INSURANCE:

1. Your insurance is a contract between you, your employer and the Insurance Company.
We are not a party to that contract.
2. We will file your primary insurance as a courtesy one time on your behalf. If the insurance company does not respond with payment within 60 days, you must pay the balance in full.
We do not file secondary insurance.
3. All deductibles and your estimated responsibilities are paid at time that services are rendered.
If there is a balance after insurance has paid, you will be billed. If there is a credit on the account after we have received your insurance payment, we will send a refund check to you. Statements that are not paid in a timely manner are subject to finance charge and late payment fee of \$25.00.

In case of default on full payment of this account, I agree to pay collection costs and attorney fees incurred in attempting to collect on this account balance.

I HAVE READ AND I UNDERSTAND THE ABOVE AND AGREE TO ABIDE BY THIS CONTRACT.

SIGNATURE _____

Patient (Parent or Guardian if Patient is a Minor)

DATE _____