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:

___Aspirin
___Bleach
___Codeine
___Dental Anesthetics
___Erythromycin
___Latex
___Metals
___Penicillin
___Other: ______________
___Sulfa Drugs
___Tetracycline

MEDICAL HISTORY:

___Abnormal Bleeding
___Anemia
___Angina
___Anxiety
___Arthritis
___Asthma
___Blood Transfusion
___Cancer
___Radiation/Chemo therapy
___Cold sores/Fever Blisters
___Congenital Heart Defect
___Diabetes
___Emphysema
___Epilepsy
___Fainting Spells
___Frequent Headaches
___Glaucoma
___*Heart Attack
___*Heart Surgery
___*Artificial Hrt Valve
___*Stent
___*Pace Maker
___High Blood Pressure
___Low Blood Pressure
___Hemophilia
___Hepatitis
___HIV/AIDS
___*Joint Replacement
___Kidney Problems
___Lupus
___*Mitral Valve Prolapse
___*Rheumatic Fever
___Seizures
___Shingles
___Sickle Cell Disease
___Sinus Problems
___*Stroke
___Thyroid Problems
___Tuberculosis
___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

___Gums bleed
___Jaw pops / clicks
___Bad breath
___Clench / grind teeth
___Removable partial / denture
___ Food caught between teeth
___Orthodontic work
___Missing teeth
___Broken teeth / chipped
___Loose teeth
___ Sensitive (circle below)
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 may 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 ______ We reserve time for your appointment.
Initials **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 ______________________________________ **DATE** ____________
Patient (Parent or Guardian if Patient is a Minor)