Anthony Dillard, DDS
FAMILY & COSMETIC DENTISTRY

Facts you should know about Dental Insurance

Dental Insurance is rapidly playing a larger and larger role in helping people obtain dental treatment. Since we strongly feel our patients deserve the best possible dental care we can provide, and in an effort to maintain the high quality of care, we would like to share some facts about dental insurance with you.

FACT #1: Dental Insurance is NOT meant to be a PAY-ALL; it is only meant to be an aid.

FACT #2: Many plans tell their insured that they will be covered "up to 80% or up to 100%". In spite of what you may have been told, we have found most plans cover about 60% to 70% of an average fee. Some plans pay more – some less. The amount your plan pays is determined by how much your employer paid for the plan. The less they paid for the insurance, the less you will receive.

FACT #3: It has been the experience of many dentists that some insurance companies tell their customers that "fees are above the usual and customary fees" rather than saying to them that "our benefits are low". Remember – you get back only what your employer puts in less the profits of the insurance company.

FACT #4: Many routine dental services are NOT covered by insurance carriers.

Please do not hesitate in asking us any questions about our office policies. We want you to be comfortable in dealing with these matters and we urge you to consult us if you have any questions regarding our services and/or fees. We will file your insurance forms at no charge.

Although this office will do everything possible to maximize your insurance benefits, YOU ARE ULTIMATELY RESPONSIBLE FOR ANY PORTION OF YOUR ACCOUNT BALANCE NOT PAID BY YOUR INSURANCE COMPANY, REGARDLESS OF THE REASON.

If you have any questions regarding your insurance, we ask that you contact your company regarding the specifics and details of the plan it is conducting on your behalf.

I have read and understood the information contained in this document.

____________________________ ____________________________

Patient Signature Date

To all our Patients:

In an effort to keep dental costs down while maintaining a high level of professional care, we have established the following payment plans for the use of our patients.

1. Payment in full for each visit is expected unless other financial arrangements have been made.
2. Our office will offer a 5% courtesy fee reduction on all fees over $500 that are paid in full by cash or check at the time of treatment.
3. A 5% courtesy fee reduction will be given to senior citizens age 55 and older.
4. Our office will accept your Visa, MasterCard, Discover or American Express credit cards.
5. We will gladly accept payments from your dental insurance company. If this is your desire, you must notify us of such at least 24 hours before your appointment so that we may have time to verify your employment and insurance benefits. Failure to do so will mean you will be expected to pay for services in full the day of the appointment. If your insurance company will not accept our standard claim form, you must supply us with a completed and signed from for each appointment. The patient will be asked to pay the portion not covered by insurance at the time of the visit. When an insurance company does not make their payment within 60 days, all fees become your responsibility – not that of the insurance company. If you require a reason for the delay please contact your insurance company. While we will do everything possible to maximize your insurance benefits, any portion of your treatment not paid for by your insurance company, regardless of the reason, will become your responsibility.
6. We offer financial consulting for other arrangements.

We appreciate your cooperation with this policy and look forward to continuing to provide optimum dentistry to you – our valued patients.

I understand that Dr. Dillard reserves the right to bill me for no-shows and/or last minute cancellations.

I have read and understand the options indicated above:

_______________________	_______________________
Patient Signature	Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, ____, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

____
____
____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ______________________________

Address: ______________________________

Telephone: ____________________ E-mail: ____________________

Patient #: ____________________ Social Security #: ____________________

SECTION B: TO THE PATIENT - READ THE FOLLOWING STATEMENT CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Nikki Maguire

Telephone: 972-394-1492

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ______________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: ______________________________ Date: ____________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ______________________________

Relationship to Patient: ______________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 About You

Today's Date: ______________________

Name: ______________________

Last First MI

I prefer to be called: ______________ ☐ Male ☐ Female

Birthdate: ____/____/____ Age: ______ SS#: ____________

Home Address: ______________________

City______________ State __________ Zip________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Work #: ______________________ Ext: ________

Home # ______________ Cell # ______________

e-mail address ______________________

DL #______________________

Employer: ______________________

Employer's Address______________________

How long there?__________ Occupation______________

Whom may we Thank for referring you?______________

Other family members seen by us:______________

Previous/Present Dentist ______________________

Last Visit Date______________________

2 Spouse Information

His/Her

Name______________________

Employer______________________

Wk # ______________ Ext______ SS ______________

Birthdate: ____/____/____ DL #______________

Person Responsible for Account ______________________

Wk #____________ Ext____________ Hm #____________

Billing Address ______________________

Relation____________ SS #______________

Employer______________________ DL #____________

3 Dental Insurance

Primary Dental Insurance

Insurance Co. Name ______________________

Insurance Co. Address______________________

____

Insurance Co. Phone #______________________

Group # (Plan, Local or Policy #)______________________

Insured's Name______________ Relation__________

Insured's Birthday ____/____/____ **Insured's SS#**__________

Insured's Employer______________________

Secondary Dental Insurance

Insurance Co. Name ______________________

Insurance Co. Address______________________

Insurance Co. Phone #______________________

Group # (Plan, Local or Policy #)______________________

Insured's Name______________ Relation__________

Insured's Birthday ____/____/____ **Insured's SS#**__________

Insured's Employer ______________________

In the event of an emergency, is there someone (not living with you) that we should contact?

His/Her Name______________________

Wk #______________ **Hm #**______________

4 Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name______________________

Phone #______________ Date of last visit__________

CONTINUED ON BACK ⇒

4 Medical History *(continued)*

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: ______________________________

Are you taking any prescription/over-the -counter drugs? ☐ Yes ☐ No

Please list each one: ______________________________

For Women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week # ____________

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y N Anemia/Radiation Treatment
Y N Artificial Bones/Joints
Y N Artificial Bones
Y N Asthma/Arthritis
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Diabetes/Tuberculosis (TB)
Y N Difficulty Breathing
Y N Drug/Alcohol Abuse
Y N Emphysema/Glaucoma
Y N Epilepsy/Seizures/Fainting
Y N Fever Blisters/Herpes
Y N Heart Attack/Stroke
Y N Heart Murmur
Y N Heart Surgery/Pacemaker
Y N Hemophilia/Abnormal Bleeding
Y N Hepatitis
Y N High/Low Blood Pressure
Y N HIV+/AIDS
Y N Hospitalized for any reason
Y N Kidney Problems
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Rheumatic/Scarlet Fever
Y N Severe/Frequent Headaches
Y N Shingles
Y N Sinus Problems
Y N Ulcers/Colitis
Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had:

____

____

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Tetracycline
Y N Other
Y N Penicillin

Please list any other drugs you are allergic to: ______________________________

____

5 Dental History

Why have you come to the dentist today?

____

____

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you floss?_______ a day do you brush?_______

Type of bristles? ☐ Hard ☐ Medium ☐ Soft

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. **I authorize the dental staff to perform any necessary dental services that I may need during the diagnosis and treatment with my informed consent.**

____

Signature Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have a question at any time, please ask us. We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein: Initials______ Date ______

Doctor's Comments: ______________________________

MEDICAL HISTORY UPDATE

1. Date: _________ Comments: ______________________________ Signature: ____________________
2. Date: _________ Comments: ______________________________ Signature: ____________________
3. Date: _________ Comments: ______________________________ Signature: ____________________