Welcome!

Verde Pointe Dental Associates
Drs. Kimmerling, McGrath & Fantaski

NEW PATIENT INFORMATION

Name_____ Preferred Name: _____Date of Birth: _____ ☐ Male ☐ Female

☐ Married ☐ Single ☐ Divorced ☐ Widowed Employer _____ ☐ College Student

Cell #_____ Work #_____ Email_____

Preferred Contact Method(s): ☐ Phone Calls ☐ Text Messages ☐ Emails ***Referred By?*** _____

Home Address: _____ Home #: _____

SSN: _____Emergency Contact_____ Phone #_____

DENTAL INSURANCE

Primary Dental Insurance Company_____Policy/Group#_____

Policy Holder's Name_____ Date of Birth _____SSN/ID#_____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Dependent ☐ Domestic Partner

Secondary Dental Insurance Company_____Policy/Group#_____

Policy Holder' Name_____ Birth of Date _____ SSN/ID#_____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Dependent ☐ Domestic Partner

DENTAL HISTORY

Reason for today's visit: _____ Year of Last Dental Visit: _____

YES	NO		YES	NO		YES	NO	
☐	☐	Hot/Cold Sensitivity	☐	☐	Grind/Clench Teeth	☐	☐	TMJ Pain/Jaw Popping
☐	☐	Past Periodontal Treatment	☐	☐	Sore/Bleeding Gums	☐	☐	Dry Mouth/Mouth Sores

Would you like to discuss? (Circle) Implants, Whitening, Crowns, Veneers, Bonding, Dentures, Straighter Teeth?

MEDICAL HISTORY

YES	NO		YES	NO		YES	NO	
☐	☐	Heart Problems	☐	☐	Kidney Disease	☐	☐	Use of Bisphosphonates
☐	☐	High Blood Pressure	☐	☐	Liver Disease	☐	☐	Pregnant (# of weeks ____)
☐	☐	Heart Valve Replacement	☐	☐	HIV / AIDS	☐	☐	Epilepsy / Seizures
☐	☐	Pacemaker	☐	☐	Hospitalized within last year	☐	☐	Hepatitis A B C (circle)
☐	☐	Diabetes (Type I or II)	☐	☐	Cancer or Chemotherapy	☐	☐	Bleeding Problems
☐	☐	Stroke	☐	☐	Joint Replacement (year ____)	☐	☐	Other (list below):

Other medical condition(s) _____

Any allergies? ☐ None ☐ Yes, please list: _____

Taking any medications? ☐ None ☐ Yes, please list: _____

_____

Print Name _____ **Relationship** _____

Signature _____ **Date** _____

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OFFICE POLICIES

Thank you for choosing us as your dental care provider. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and comfortable as possible throughout our relationship. We encourage you to ask questions and be involved in treatment decisions. Please understand that payment of your bill is considered a part of your treatment.

Insurance

Our office will file and accept your dental insurance, however, understand that it is solely your responsibility to confirm which treatments or procedures are covered or not covered by your insurance policy. As a courtesy, we will attempt to verify your insurance coverage from the information that is provided to us and we will file a claim for each visit. Please understand that although you pay your estimated patient balance on the date of service, the estimate may differ from what your insurance ultimately pays. There is no guarantee of payment until a claim has been processed. You will be responsible for any amounts not paid by the insurance for any reason, and you may receive a bill/statement for any balances due which will be mailed immediately payable upon request.

Broken/Canceled Appointments

In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. **I understand I will be charged a $75 cancellation fee for any cancellation notice less than 24 hours.** Please call our office for emergencies; we do understand when unforeseen situations come up and will try our best to make an exception for you. After 3 missed appointments, we will place you on a short call list, which means we will phone you when an appointment time becomes available on short notice.

Treatment Plan Estimates

Our patients may request a treatment plan estimate so that patients can understand their estimated costs of their recommended treatment prior to its start. This estimate is a good-faith attempt to predict the cost of your treatment based on the facts known to us when the estimate is made. All our doctors diagnose treatment based on your dental needs not by what your insurance covers. For example, your dentist may recommend a crown that has extensive decay, however, your insurance may only cover the cost of a filling. This does not mean it is not medically necessary, only that your insurance benefit is limited to a filling only. As your treatment progresses, your dentist may determine in consultation with you that different or additional treatment is necessary, and your financial responsibility may change.

Payments/Co-Payments

Patients are expected to pay for services at the time they are rendered. Our patients who have dental insurance are expected to pay that amount of their ESTIMATED co-pay and deductible at the time of service. Payments may be made using Cash, Check, Visa, MasterCard, Discover and American Express. We also offer CARECREDIT, which gives our patients the option to finance their dental treatment while making low monthly payments with no interest applied. CARECREDIT is based upon credit approval. An application can be filled out right here in our office and all decisions are made instantly.

Account Balances/Collections

I acknowledge that all noncurrent balances and accounts over sixty (60) days shall incur a service charge 1.5% per month (18% annually) on any unpaid balances. The cost incurred in collecting this account including court fees, agency fees and attorney fees shall be added to your balance due. We have the right to report your account to a collection agency and/or take legal action against you for full payment, including any fees that have incurred.

_____(initial) I give consent to receive all necessary dental treatment, education, and other dental-related services. I have the right to withdraw this consent at any time in writing.

_____(initial) I acknowledge the Notice of Privacy Policy. I understand that I may receive a copy upon request or refuse to sign this acknowledgement.

_____(initial) Please share my dental treatment needs and financial information with _____.

FOR MINORS ONLY:

_____(initial) I authorize my minor to seek previously authorized treatment without a guardian present. The adult accompanying the minor and / or the parents (guardians) are still responsible for payment in full at the time of service.

_____	_____	_____
Print Name	Signature	Date

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Authorization for Release/Use of Protected Health Information in the Form of Photos, Radiographs, and Electronic Images

Name of office: Verde Pointe Dental Associates

Your photos and x-rays are part of your diagnostic and clinical record and are protected health information under federal HIPAA Privacy Laws.

We make use of radiographs (x-rays), photographs, and digital images. These images may be used for diagnosis, documentation, reference, teaching, and research publication. Some cases that present exceptional results, and/or particularly remarkable smiles, and/or interesting and/or fun situations may be utilized for demonstration, education, or advertising to potential and existing patients in our office either in print media, social media, television, on digital media and on our webpage. In some instances, you may be recognizable in some of these images.

By initialing and signing this form, you are authorizing us and releasing us from any liability resulting from the use/release of such images. Your authorization and release to use images will in no way affect the quality of your results in our office. We do our best to provide exceptional dentistry to all patients.

___ I authorize the use of my images where my face is identifiable
___ I authorize the use of my images where only my teeth are identifiable
___ I authorize the use of my radiographs

___ I do NOT authorize the use of any of my images

The purpose of this request to release and/or disclose the PHI described above is for personal reasons. I understand that I have the right to revoke this Authorization, in writing, at any time by notifying the office above. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by this rule.

I understand that my health care provider cannot condition treatment on whether I sign this authorization.

_____ _____
Signature of Patient Date

_____
Print Name