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625 Three Springs Road • Bowling Green, KY 42104 • (270) 782-5115

Patient Information

Patient Name _____ Date _____
Last, First MI (Preferred Name)
Gender: _____ Family Status: _____ Social Security #: _____ Birth Date: _____
Email Address: _____
Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone: _____
Address: _____
Street Apartment #
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | | |
|---|---|--|---|---|
| ☐ A-Fib | ☐ Cancer | ☐ Hepatitis | ☐ Currently Pregnant | ☐ Tobacco User |
| ☐ Acid Reflux | ☐ Diabetes | ☐ Hereditary Angioedema | Due date: _____ | ☐ Tuberculosis |
| ☐ AIDS | ☐ Dizziness | ☐ High Blood Pressure | ☐ Radiation Treatment | ☐ Tumors |
| ☐ Allergies _____ | ☐ Epilepsy | ☐ Jaundice | ☐ Respiratory Problems | ☐ Ulcers |
| ☐ Alzheimer's/Dementia | ☐ Excessive Bleeding | ☐ Kidney Disease | ☐ Rheumatic Fever | ☐ Venereal Disease |
| ☐ Anemia | ☐ Fainting | ☐ Liver Disease | ☐ Rheumatism | ☐ Codeine Allergy |
| ☐ Arthritis | ☐ Glaucoma | ☐ Mental Disorders | ☐ Seizures | ☐ Penicillin Allergy |
| ☐ Artificial Joints | ☐ Hay Fever | ☐ Neck Injuries | ☐ Sinus Problems | ☐ Latex Allergy |
| ☐ Asthma | ☐ Head Injuries | ☐ Nervous Disorders | ☐ Stomach Problems | OTHER |
| ☐ Blood Disease | ☐ Heart Disease | ☐ Osteoporosis | ☐ Stroke | ☐ _____ |
| | ☐ Heart Murmur | ☐ Pacemaker | ☐ Teeth Grinding | ☐ _____ |

• Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

• Please list any serious illness, operation, or hospitalization in the last 5 years.

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

If yes, please explain: _____

• Primary Care Physician: _____ Phone: _____

• Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain: _____

Please list any medications: _____

Emergency Contact: _____ Relation to Patient: _____ Phone: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct.
If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian Date: _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Simon Dentistry

Spouse or Responsible Party Information

Name: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone: _____
Address: _____
Street Apartment #
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment
Employer Name: _____ Occupation: _____
Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____
Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____
Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____



HIPAA AUTHORIZATION FORM

Patient Name: _____ Date: _____

May we share your Protected Health Information with a family member or other person? ☐ Yes; ☐ No;

If yes: _____
Name(s)

May we leave messages on your HOME Voice Mail? ☐ Yes; ☐ No; Phone #: _____

May we leave messages on your MOBILE Voice Mail? ☐ Yes; ☐ No; Phone #: _____

By signing, I authorize this practice **Simon Dentistry** to use/or disclose certain protected health and/or financial information about me to any doctor or health care facility that they refer me to with my consent and understanding OR to the above-named person/entity. This authorization permits the above-named practice to use and/or disclose the following individually identifiable health information about me, including but not necessarily limited to: handwritten, digital notes & chartings, diagnosis, radiographs, photographs, lab, prescriptions, therapeutic, treatment records. The information will be used or disclosed for the following purposes: To assist other healthcare providers/entities in providing your health care OR for insurance billing and receiving payments on your behalf. (If disclosure is requested by the patient, purpose may be listed as "at the request of the individual."). Included in this section is any entity that you have authorized to receive your medical records. In such cases, ALL your chart data will be provided unless the request explicitly requests only specific information.

I HAVE BEEN INFORMED THROUGH THIS DOCUMENT THAT A PRINTED COPY OF THE FULL HIPAA LAW IS AVAILABLE TO ME BY VERBAL REQUEST AT THE TIME OF SIGNING AND UNDERSTAND THAT I MAY REVOKE THIS SIGNED DOCUMENT AT ANYTIME BY CONTACTING THIS DENTAL OFFICE.

Please check one:

☐ **I DO consent** to send and receive email communication and/or text messages that do not use encryption services to and from this dental office and to have my insurance claims sent on my behalf. X_____ (Initial)

☐ **I DO NOT consent** to receive email communication and/or text messages. I understand that all communication and documents must be picked up in person or sent via certified mail via scanned documents on a CD disc at my personal expense. All electronic insurance claims will be my sole responsibility. X_____ (Initial)

☐ **I DO** give advance permission to this dental office to release my dental radiographs and/or records to my personal email address only if I ever request this in the future. I understand this request may be made over the phone for my convenience but will ONLY be sent to the email address that I write today. I acknowledge it may take ten business days to process my request. X_____ (Initial)

Email address: _____

The purpose(s) of this form is to help me make an informed decision regarding whether to allow release of my protected health information. I understand that this authorization will not expire until a written request to revoke this authorization is received by this dental office. I understand that if this practice bills dental insurance on my behalf, the practice must exchange or disclose my PHI (protected health information) in order to receive payment or other remuneration from a third party.

I do not have to sign this authorization to receive treatment from Simon Dentistry. I understand that if I refuse to sign this form, insurance cannot be billed on my behalf and that I will be responsible to pay for all services in advance. I also have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it might be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at this address: 625 Three Springs Road, Bowling Green, KY 42104

Signature of Patient/Legal Guardian: _____ Date: _____



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FINANCIAL POLICY

Our mission is to provide you with a family-like atmosphere in an up-to-date facility where you can be certain that you are given the very best care for your dental needs. In addition, we recognize the need for a clear understanding of your financial obligations for the treatment you receive. In order to create a better understanding between patients and our office, we have adopted the following policy. If you have any questions about this policy, we encourage you to contact our Patient Accounts Department.

PATIENTS WITHOUT INSURANCE COVERAGE

Unless prior arrangements are made with our Patient Accounts Department, **payment in full is due on the day of service.** For your convenience we accept cash, check, Care Credit, Sunbit, and all major credit cards. For dental procedures over \$200.00, a 15% cash discount will be applied if the patient's balance is paid in full on the day of service. To receive this discount payments must be made with cash or check only. A discount cannot be given for any implant, Zoom and Botox® procedures.

PATIENTS WITH INSURANCE COVERAGE

We participate with numerous insurance plans and will gladly file your dental claim for you. This is a service provided by the office. Benefits will be assigned to us and insurance payments will be made directly to the office. We will attempt to collect payment from the insurance company for up to 90 days. If payment is not received in that amount of time, the patient will be held responsible for payment. We will gladly continue to assist you in recovering payment from the insurance company. Deductibles and co-payments are due on the day of service. **Ultimately, the patient is responsible for the balance in full if payment is not received from the insurance company.**

RETURNED CHECKS

Returned checks will incur a \$25.00 service fee.

COLLECTION

The undersigned understands and agrees that the account balance is due, in full, upon receipt of the statement. If the account is not paid in full within 90 days from the date of service, and Simon Dentistry should retain an attorney or collection agency for collection, the undersigned agrees to reimburse Simon Dentistry the collection fees of any collection agency, which shall be based on a percentage at a maximum rate of 33 1/3% of the amount due at the time your account is placed with a collection agency, and all costs and expenses incurred for any collection agency. This contract shall cover all dental treatment and services until revoked by either party in writing.

FINANCING OPTIONS

Because your smile is important to us, we offer Sunbit which can help you smile now and pay-over-time with flexible payment plans. We also accept Care Credit, a healthcare credit card specifically designed to pay for procedures not covered by insurance. Ask us about your financing options today, and how you may qualify for deferred or no interest financing.

MISSED APPOINTMENT FEE

As a courtesy to our office, we ask our patients to give a 24–48-hour notice if the scheduled appointment must be broken. However, if the requested notice or no notice is given, a missed appointment or cancelled appointment fee of \$50.00 will be charged to the patient's billing statement.

SIGNATURE OF PATIENT OR GUARDIAN: _____ **DATE:** _____