PATIENT INFORMATION

EMAIL ADDRESS: _____ CELL PHONE: _____

NAME: _____ HOME PHONE: _____

ADDRESS: _____ APT. # _____ CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY NUMBER: _____ ; ATTENDING SCHOOL YES NO; GRADE ____; NAME _____

EMPLOYED	SEX	DATE OF	MONTH	DAY	YEAR	AGE	MARITAL STATUS	WEIGHT	HEIGHT	EYES (COLOR)
❑ YES ❑ NO	❑ M ❑ F	BIRTH					❑ S ❑ M ❑ W ❑ D			

EMPLOYER'S NAME: OCCUPATION:

EMPLOYER'S ADDRESS: CITY: STATE: ZIP: BUS. PH #:

PARTY RESPONSIBLE FOR THIS ACCOUNT

NAME: SPOUSE NAME: HOME PH#:

ADDRESS: - SOCIAL SECURITY NO.:

EMPLOYED	SEX	DATE OF	MONTH	DAY	YEAR	AGE	MARITAL STATUS	WEIGHT	HEIGHT	EYES (COLOR)
❑ YES ❑ NO	❑ M ❑ F	BIRTH					❑ S ❑ M ❑ W ❑ D			

RELATIONSHIP TO PATIENT: OCCUPATION:

EMPLOYER'S NAME: BUSINESS PH# EXT#

EMPLOYER'S ADDRESS: CITY: STATE: ZIP:

PAYMENTS TO BE MADE BY

CASH ❑ YES | MASTER CARD ACCOUNT # EXP. DATE | VISA ACCOUNT# EXP. DATE | CHECK BANK A/C#

RESPONSIBLE PARTY INSURANCE

PATIENT OR GUARDIAN DENTAL INSURANCE ❑ YES ❑ NO

INSURANCE NAME: PH# INSURED PARTY S/S#

EMPLOYER: GROUP OR POLICY#

SEND CLAIMS TO: COVERAGE: ❑ SINGLE ❑ FAMILY

SPOUSE DENTAL INSURANCE ❑ YES ❑ NO

SPOUSE NAME: DOB SOCIAL SECURITY#

SPOUSE INSURANCE NAME: PHONE #

EMPLOYER: GROUP OR POLICY#

SEND CLAIMS TO: COVERAGE: ❑ SINGLE ❑ FAMILY

OTHER

PREVIOUS DENTIST'S NAME & ADDRESS

PHYSICIAN'S NAME & ADDRESS

IN CASE OF EMERGENCY NOTIFY (NOT LIVING WITH PATIENT) NAME:

RELATIONSHIP TO PATIENT: PHONE (NO(S):

WHOM SHALL WE THANK FOR REFERRING YOU?

DRIVER'S LICENSE NO. (Individual responsible for account only) STATE

Medical Information Required On Reverse Side If Emergency

I hereby acknowledge above information is true and correct:

Signed: _____ Date: _____

Party Responsible for Account

DR PATIENT ACCOUNT NO.

FOR OFFICE USE

M 166447 7/02/99 ITEM 6151

PLEASE FILL OUT THESE PATIENT FORMS AND BRING THEM WITH YOU TO YOUR APPOINTMENT WITH DR. CHIAFAIR

MEDICAL HISTORY (PLEASE CIRCLE YES OR NO) BP / PULSE

1. Has there been a recent change in your health? ..... No Yes
   If yes, please explain: _____
2. When was your last examination? _____
3. Are you under the care of a physician? ..... No Yes
   If yes, condition: _____
4. Have you been hospitalized or had a serious illness within the last 5 years? ..... No Yes
   If yes, what was the problem? _____
5. Do you have or have you had any of the following? ..... No Yes
   (Please check appropriate conditions)

☐ Rheumatic Fever or Heart Problems	☐ HIV Infection or Aids	☐ Asthma or Hay Fever
☐ Abnormal Bleeding/Blood Disorders	☐ Kidney Problems	☐ Fainting Spells or Seizures
☐ Arthritis or Rheumatism	☐ Venereal Disease	☐ Tuberculosis
☐ Hepatitis, Jaundice or Liver Disease	☐ Orthopedic Appliances	☐ Radiation Therapy
☐ Circulatory Problems	☐ Thyroid Problems	☐ High/Low Blood Pressure
☐ GI Problems (Ulcers)	☐ Surgical Procedures	☐ Heart Murmur
☐ Diabetes	☐ Radiation Treatment	☐ Other _____
	☐ Nervous Problems	

6. Do you have any difficulty breathing through your nose? ..... No Yes
7. Are you currently taking any medication, either prescribed or over the counter? ..... No Yes
   If yes, list _____
8. Are you allergic to any drugs or medications such as Penicillin, Codeine, Aspirin or local anesthetics? ..... No Yes
   If yes, what _____
9. Do you have any disease condition or other problems listed above that you think I should know about? ..... No Yes
   If yes, describe _____
10. Are you aware of any lumps in your mouth? ..... No Yes
11. Do you use tobacco products? ..... No Yes

WOMEN ONLY

1. Are you pregnant? If so, how many months? _____ No Yes
2. Are you taking birth control pills? ..... No Yes

DENTAL HISTORY

1. Are you aware of any dental problems at this time? ..... No Yes
2. When was your last dental visit? _____
   What was performed? _____
3. Are you seen in a dental office on a regular basis? ..... Yes No
4. Have you had a set of full mouth X-rays in the last 3 years? ..... No Yes
   If no, when was the last set? _____
5. Have you had a dental cleaning within the last year? ..... Yes No
   If not, when was your last cleaning? _____
6. Have you had any of the following treatment? Orthodontics, Endodontics (Root Canal), Periodontics ..... No Yes
   (Gum Therapy). If yes, please specify: _____
7. Do you experience pain or clicking in your jaw, ear, or facial muscles upon opening your mouth? ..... No Yes
8. Have you ever had instructions in oral hygiene technique? ..... Yes No
9. How often do you brush your teeth? _____
10. Do your gums bleed? ..... No Yes
11. Are you aware of grinding or clenching your teeth? ..... No Yes
12. Do you suffer anxiety or gagging during dental procedures? ..... No Yes
13. How are your teeth important to you? _____
14. Do you want to avoid dentures? Why: _____ Yes No
15. Are you unhappy with the appearance of your teeth? ..... No Yes
    Why: _____
16. What changes would you make? _____
17. Interests and hobbies? _____

Patient's (or Guardian's) Signature _____ Date: _____

Reviewed by _____ Date: _____

Dr. Joseph G. Chiafair, D.D.S & Associates

AUTHORIZATION OF RELEASE AND ASSIGNMENT

I hereby authorize the release of X-rays or any information necessary for insurance, transferring of records, workman's compensation, collection, etc.

I assign all benefits from my dental insurance to Joseph G. Chiafair D.D.S., M.S. P.A. and Associates until cancellation in writing to the office.

I understand that I am responsible for all charges incurred and that the insurance contract is between myself and the insurance company. It is not the responsibility of Joseph G. Chiafair D.D.S., M.S. P.A. or Associates to collect from the insurance company. If we have agreed to accept assignment, the insurance company is given 30 days to pay, and then the balance not paid by insurance is due within 10 days. Payment is due when services are rendered unless special arrangements have been made prior to your appointment. If assignment of benefits has been accepted, you the responsible party, are required to pay your deductible and any portion the office feels the insurance will deny at the time of services.

Signature _____ Date _____

If signed by patient representative, state relationship to patient _____

Dr. Joseph G. Chiafair, D.D.S & Associates

HIPAA CONSENT FORM

I give this participating practice my consent to use or disclose my health/dental information to carry out my treatment to obtain payment from insurance company and for health/dental care operations.

I have been informed that I may review the practice notice of privacy practices (for a more complete description of users and disclosures) before signing the consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a description of how my protected health/ dental information are used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction(s) they must follow the restriction(s).

I also understand that I may receive this consent at any time by making a request in writing, except for the information already used or disclosed.

Signature _____ Date _____

If signed by patient representative, state relationship to patient _____

Dr. Joseph G. Chiafair, D.D.S & Associates

Dear Patient,

We appreciate you allowing us to provide you with dental care and value our relationship with you. The best relationships are those based on understanding, so we offer these methods for your services rendered.

(A) You are responsible for payment in full for co-pay or deductible at each appointment as services are rendered unless arrangements have been made prior. We accept cash, checks with a valid driver's license, Visa or MasterCard.

(B) As a courtesy to our patients, we accept most insurance carriers as an out of network provider, and we directly submit your claim. However, if ew do not receive payment from your insurance company within 45 days of submission, you will be expected to pay for the balance on services rendered. We will promptly refund you payment once your insurance payment has been received.

We feel it is appropriate to clarify a possible misconception you may have regarding insurance company payment of claims. Most insurance companies do not pay 100% of the dental bill. In most cases, you the patient are responsible for the balance of the total bill. Each insurance company has different rules, regulations, and coverage guarantees. Your understanding of this will avoid surprises later.

Our office policy states that you are responsible for the total bill. We will gladly file your insurance claim as a courtesy. However, once the insurance claim has been paid, any balance left is your responsibility as the patient.

We will assist you in every way to understand the terms of your insurance coverage pertaining to dental services as well as our need for your bill to be paid in full within (30) thirty days of the issued bill.

(C) Financial arrangements must be made prior to treatment.

(D) Unpaid bills over (45) forty-five days are subject to collection fees. Return check fee is ($30) thirty dollars per check, and we will not resubmit returned checks to the bank for payment.

(E) All billing is processed by the last day of the month. Payments are due by the 15th of every month.

I have the right at any time to pay the unpaid balance due under any agreement. Payment hereunder is due on the date as set forth above, and late payments will be assessed a late charge at the rate of 18% per annum (1 1/2% per month) on the past due balance of the account. In the event the balance due is filed for collection under office policy, the responsible party will be liable for all attorney fees and costs in connection with same as well as late charges. The responsible party will also be responsible for all collection fees. Fees quoted are in effect for (90) ninety days. Fees are subject to change if treatment does not commence within 90 days.

We look forward to years of close association with you as we work together to maintain your dental health.

Signature _____ Date _____

If signed by patient representative, state relationship to patient _____