PatriotDental

Dr. Andrew Ducote, D.D.S.

PATIENT INFORMATION (CONFIDENTIAL)

Please complete both sides of this form to the best of your abilities. (PLEASE PRINT)

Patient's Name _____ Preferred Name _____

Date of Birth _____ Soc. Sec. # _____ Email _____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____

Spouse's Name _____ Employer _____ Contact # _____

Emergency Contact Person: _____ Phone # _____

Whom May We Thank for referring you? ☐ Friend/Family _____ ☐ Insurance ☐ Bing

☐ Google ☐ Drive-By ☐ Yelp ☐ Website ☐ Other _____

If the patient is not responsible for payment of this account please complete the following information:

RESPONSIBLE PARTY

Responsible Person's Name _____

Home Address _____

Relationship to Patient _____ Soc. Sec. # _____ DOB _____

Home Phone _____ Work Phone _____ Alternative Phone _____

Employer _____ Address _____

INSURANCE INFORMATION

Policy Holder's Name _____ S.S.# _____ DOB _____

Employer _____ Address _____ Work# _____

Insurance Company _____ Phone _____

Insurance Company Address _____

Policy ID # _____ Group # _____

X_____ _____

Signature of Patient or Parent/Guardian if Minor Date

PATIENT MEDICAL HISTORY

Patient Name _____ DOB _____ Date _____

Although general dentistry primarily treats the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications you may be taking, could have an important interrelationship with the treatment that you will be receiving. Thank you for answering the following questions.

Are you in good health? **Y** **N**

Have there been any changes in your general health within the past year? **Y** **N**

Are you now under the care of a Physician? **Y** **N**

Have you ever been hospitalized for any surgical operation or serious illness? **Y** **N**
_____
_____
_____

Are you taking any medications? **Y** **N**

If yes, what medications are you taking: _____
_____

Have you had any abnormal bleeding? **Y** **N**

Do you bruise easy? **Y** **N**

Date of your last physical exam: _____
Physician's Name: _____
Address: _____
Phone: _____

Date of your last dental treatment or cleaning. _____

What do you like best about your teeth? _____

What do you like least about your teeth? _____

What would you change about your teeth? _____

Do you have any of the following?

Gum Disease	Halitosis	Bruxism	Abscesses
Sensitivities	TMJ	Ulcers	Cold Sores
Pain in Jaw			

Are you currently experiencing a toothache or pain? **Y** **N**

Are there any other conditions which we should be aware of? **Y** **N**
Please explain: _____
_____

WOMEN ONLY

Are you pregnant or think you may be pregnant? **Y** **N**

Are you nursing? **Y** **N**

Are you taking birth control pills? _____ **Y** **N**

Are you allergic to or have you had reactions to:

Aspirin_____ Penicillin_____ Codeine_____ Novocaine_____ Metal_____ Latex Rubber_____
Local Anesthetics_____ Iodine_____ Sulfa drugs_____ Barbiturates or sleeping pills_____

Do you now have or have you ever had any of the following? Please check if appropriate.

☐ Heart Murmur	☐ Stroke	☐ Hemophilia	☐ Tumors/Growth	☐ Liver Disease	☐ Venereal Disease
☐ Pacemaker	☐ Leukemia	☐ Emphysema	☐ Hepatitis A, B or C	☐ Rheumatic Fever	☐ High Blood Pressure
☐ Heart Surgery	☐ Cancer	☐ Kidney Disease	☐ Stomach Ulcer	☐ Lung Disease	☐ Low Blood Pressure
☐ Heart Trouble	☐ Blood Disease	☐ Thyroid Problems	☐ Breathing Problems	☐ Immune Deficiencies	☐ TMJ
☐ Artificial Heart Valve	☐ Artificial Joint	☐ Anemia	☐ Asthma	☐ Diabetes	☐ HIV Positive
☐ Mitral Valve Prolapse	☐ Glaucoma	☐ Epilepsy/Seizure	☐ Psychiatric Care	☐ Tuberculosis	☐ Sinus Trouble

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I will inform the Dentist and staff at the next appointment without fail. I will not hold my Dentist or any staff members responsible for any errors or omissions that I may have made in the completion of this form

X _____ **Date** _____
(Patient signature / Parent or Guardian signature)

Reviewed by Dentist _____ Date _____ BP _____

History Reviewed and Significant Findings _____
_____
_____
_____

NOTICE TO PATIENTS, INSUREDS, AND GUARANTORS

DENTAL PLAN DENIALS

Your dental plan will only pay the dentist if the services you received are covered services under the terms and conditions of the dental plan. If you are a member of a Preferred Provider Organization, or an Indemnity plan, your dental plan may reduce or deny some or all benefits if:

- They consider services are not dentally necessary
- The service is not a covered service.

Dental plans review these services to determine if the services are dentally necessary. Generally, dentally necessary means services which are:

- Appriopratiate and necessary for the symptoms, diagnosis or treatment of a dental problem.
- Not primarily for cosmetic purposes of the dental plan member or the member's dependants.
- The least costly of alternative supplies or level of service which can be safely and effectively provided to the patient.

We cannot accept the financial risk for services which you receive, which are subsequently determined by your dental plan to not be dentally necessary. Your financial agreement with the dentist is that you will ultimately be responsible to pay for all services you received whether or not the dental plan determines the services to be covered services or dentally necessary.

The undersigned certifies he/she has read the foregoing, receiving a copy if requested thereof, and is the patient, the patient's guardian, insured or guarantor, and accepts its terms.

_____ _____

Patient, Insured / Guarantor, Guardian (Signature) Name of Patient (Printed)

_____

Date

FINANCIAL POLICY

Our mission is to deliver the finest most cost effective Dental Care available today. Following diagnosis, the Dentist will advise you on a plan for treatment. Additionally, we will discuss with you the cost of today's and any future treatment.

Payment for today's visit and your future visits are due at time of treatment. In an effort to make general dentistry more affordable for you, we participate in two basic types of dental benefit programs.

- **PPO (Preferred Provider Organization)** type programs are preferred providers which entitle the participant to contracted reduced fees according to their plan fee schedules. These plans generally have a percentage of the fees that are paid by the patient at the time treatment is rendered. Your insurance policy is a contract between you and your insurance company. The estimate provided by our office is considered as a guideline until final insurance payment, if any, is received and the patient's account has been paid in full. **We make no guarantee of the insurance payment as estimated**. Claims are submitted promptly after treatment is rendered, and if not paid by the patient's insurance company by the 60th day after treatment is rendered, the total outstanding account balance will be billed directly to the patient.

- **Indemnity Dental Insurance** allows for your reimbursement of a percentage of the fees for treatment services. Your insurance policy is a contract between you and your insurance company. When we accept your insurance company's assignment, it does not absolve you from full responsibility for your charges in full for the treatment rendered. The estimate provided by our office is considered as a guideline until final insurance payment, if any, is received and the patient's account has been paid in full. **We make no guarantee of the insurance payment as estimated**. The agreed upon payment plan for the patient's estimate portion must be kept current or the assignment will be cancelled and the full amount will become due and payable. Claims are submitted promptly after treatment is rendered, and if not paid by the patient's insurance company by the 60th day after treatment is rendered, the total outstanding account balance will be billed directly to the patient.

Our Team prides itself on helping our patients maximize their benefits. We are always available to answer any questions you may have regarding your treatment. **Predetermination** - Another way of determining your liability is to have our office file a Predetermination of benefits. Dental benefits plans suggest predetermination for specific procedures or when covered charges are expected to exceed a certain amount. Predetermination may take up to six weeks to process by your insurance, thereby delaying the start of your treatment and is still only an estimate and not guarantee of payment by your insurance.

The existence of a dental procedure code does not mean that a procedure is covered or a reimbursed benefit in a dental benefit plan. It is not easy for an office to become familiar with the details of every dental plan it encounters. **And it is, of course, the responsibility of the patient, not the dental office, to know what is covered and what is excluded from her/his dental plan**. **In order to cover deductibles, co-payment, or fee downgrades, we collect sixty percent of any amount billed to your insurance company at the time of service.** After insurance payments have been received and posted a refund check will be reimbursed to you if your account carries a credit.

There will be a $35.00 cancellation fee for any broken/missed appointments without 24 hours prior notice. Future appointments will not be scheduled until this fee is paid. If you reach 3 broken/missed appointments you will be terminated from the practice.

Payment Options

- Cash – includes money order and personal checks.
- Credit Card – to include Visa, Master Card.
- Care Credit–offers a separate line of credit to cover your entire family's Dental needs.

It is Your Responsibility to pay for services at the time you receive them, regardless of any dental plan or insurance benefits you may have. We will provide monthly statements on accounts that have a balance. Unpaid account balances greater than 60 days will be charged a finance charge of 5% per month.

By signing below, I understand that I am financially responsible for all charges whether or not my insurance covers them. I hereby assign my insurance benefits be paid to Patriot Dental. I also authorize the Dentist to release to my insurance carrier(s), any information required to process any claim(s).

Patient's Name: _____

Signature of Responsible Party: _____ Date: _____

HIPPA PRIVACY
ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I, _____ [Please print full legal name here] (the "Patient" or "Patient's legal representative"), have been presented with the Notice of Privacy policy (the "Policy") of Patriot Dental, and have been offered a copy of such policy to keep for my records.

_____ [Please initial here] I hereby acknowledge that I have read the Policy and understand its terms and conditions.

_____ [Please initial here] I hereby refuse to acknowledge receipt of the Policy and refuse to read or acknowledge any of the terms and conditions of the Policy. I understand that even though I may refuse to sign this acknowledgement, Provider may still provide treatment to me.

_____
Signature of Patient Date

For Office Use Only

I,_____ [Please print full legal name here], acting as

_____ [Please print relationship to or official position with Provider] for Provider attempted to obtain written acknowledgement of receipt of the Policy of Provider on _____ [Please insert date attempt was made], but acknowledgement could not be obtained because:

_____ [Please initial here] Patient or Patient's legal representative refused to sign.

_____ [Please initial here] Patient or Patient's legal representative could not be communicated with sufficient to obtain acknowledgment.

_____ [Please initial here] Emergency Circumstances prevented securing acknowledgement.

_____ [Please initial here] Other (Please specify) _____

_____

_____

_____

_____
Signature of Provider Representative Date

Patriot Dental

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.
The privacy of your health information is important to us.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notices effective for all health information that we maintain, including health information that we maintain, including health information we created or received before we made the changes. In the event we make the material change in our privacy practices, we will change this notice and provided it for you.

Uses and disclosures of health information

We use and disclose health information about your treatment, payment, and treatment operations. For example:

Treatment: we may use and disclose your health information to a dentist or other healthcare provider providing treatment to you for: (a) the provision, coordination, or management of health care providers; (b) consultation of health care providers relating to the patient; or (c) the referral of a patient from one health provider to another.

Payment: we may use and disclose your health information to obtain payment for the services provide to you. This may include: (a) billing and collection activities and relating data processing: (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Healthcare operations: we may use and disclose your health information in connection with our healthcare operations. Healthcare operations include things such as quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities

Your authorization: in addition to our use of your health information for treatment, payment or healthcare operations .Healthcare operations, you may give us written authorization to use your health information to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

Marketing health care products or services: we will not use your health information for marketing communications without your prior written authorization. We may provide you with information regarding product or services that we offer related to your health care needs, we will never sell your health information without your prior authorization.

To your family and friends: we may disclose your health information to you, as describe in the patient rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you a agree that we may do so or, if you are not able to agree, if it is necessary in our professional judgment.

Persons involved in care: we may use or disclose information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice, medical supplies, x-rays, or other similar forms of health information.

Require by law: we may use or disclose your health information when we are require to do so by law, including judicial and administrative proceedings.

Abuse or neglect: we may disclose your health information to appropriate authorities if we reasonable believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious treat to your health information of inmate or patient under other circumstances.

National security: we may disclose to military authorities the health information or to the armed forces personnel under certain circumstances. We may disclose to federal officials health information require for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institute or law enforcement officials having lawful custody of protected health related benefits and services that may be of interest to you.

Appointment reminders and treatment alternatives: we may use or disclose your health information to provide to you with an appointment remainders (such as voice mail messages, postcards, or letters) or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Patient rights

Access: you have the right to review or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicable do so. You must make a request in writing to obtain access to your information. You may obtain a form to request access by using the contact information listed at the end of this notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this notice. If you request an alternative format, we will charge you a cost-based fee for providing your health information in the format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Disclosure Accounting: you have the right to receive a list of instances in which we or our business associates disclose your health information for purposes, other than treatment, healthcare operations, where you have provided an authorization and certain other activities, for the last 6 years, but not for disclosure prior to April 14, 2003. If you request this accounting more than once in a12- month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: you have the right to request that we place additional restrictions on our use or disclosures of your health information. We are not required to agree to these additional restrictions, but if we do so, we will abide by our agreement (except in an emergency).

Alternative communication: you have the right to request in writing that we communicate with you about your health information by alternative means or to alternative locations. Your request must specify the alternative mean of location and provide satisfactory explanation how payments will be handled under the alternative means or location request.

Amendment: you have the right to request that we amend the health information. Your request may be in writing and must explain why the information must be amended. We may deny your request under certain circumstances.

Electronic Notice: if you receive this notice in our website or by electronic mail (e-mail), you are entitled to receive this notice in written form.

Questions or Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concern that we may violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the disclosure of you health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complain to the U.S. Department of health and human services. We will provide you with the address to file your complain with the U.S. department of Health and Human Services upon request

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. department of Health and Human Services. **Contact**:

Elizabeth Jimenez- Office Manager: (512) 244-3991 Fax (512) 244-6375