RUTLEDGE
DENTAL ASSOCIATES
Family and Cosmetic Dentistry

Name: _____ DOB: _____

☐ Single ☐ Married ☐ Widow ☐ Divorced

Social Security # _____ Driver's License # _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Insurance Information

Primary Dental Insurance: _____

ID # _____ Group # _____

Policy Holder*: _____ *IF SAME AS PATEINT, WRITE "SAME AS PATIENT"

Policy Holder DOB: _____ Social Security # _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Policy Holder Occupation: _____

Employer's Address: _____

_____

Secondary Dental Insurance: _____

ID # _____ Group # _____

Policy Holder*: _____ *IF SAME AS PATEINT, WRITE "SAME AS PATIENT"

Policy Holder DOB: _____ Social Security # _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Policy Holder Occupation: _____

Employer's Address: _____

_____

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Emergency Contact

Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Referral

Who selected this office?

☐ Self ☐ Spouse ☐ Parent ☐ Employer ☐ Other _____

How did you find out about us?

☐ Referred by a friend ☐ Referred by a family member ☐ Internet

☐ Direct Mailing ☐ Newspaper Ad ☐ Yellow Pages ☐ Sign by building

☐ Other _____

If you were referred, who may we thank for referring? _____

Payment Policy

We deliver the finest care at the most reasonable cost to our patients. To help reduce our administrative costs and keep our fees to you as low as possible, we require payments to be made at or prior to the time that you (or your family members) receive treatment. We accept the following methods of payment listed below:

- Cash or Check* (electronic depositing with a valid driver's license)

All Checks will be deposited the same day received. Patient / Responsible Party is responsible for a $25 returned check fee

- Major credit card (Visa, MasterCard, American Express or Discover)
- HSA/ Flex spending cards (Please Note: We are unable to issue refunds and will not be held responsible for services charged to them that are not in compliance with your specific plan. Please check before using these cards.
- Balances over 90 days will accumulate interest charges.
- In the unfortunate event that an account is reported to a collection agency, a 35% collection fee will be added to any outstanding balance.

Patients Using Dental Insurance:

Dental insurance is a great adjunct to help offset some of the costs of dental treatment. Generally, dental insurance only pays a portion of dental care and is a contract between you and your insurance company. We will be happy to bill to your secondary insurance as long as it is presented before the service has been rendered. Our office will collect any deductibles and estimated patient responsibility based on the dental insurance benefits at the time services are rendered. After the primary insurance payment is received, you will be billed for any difference between the anticipated insurance payment and the actual insurance payment. If the insurance payment is greater than the estimation, we will either refund the amount to you upon your request or leave the credit balance on your account to be applied toward future treatment. Should your insurance company fail to pay their portion within 60 days after we submit your claim, you will be responsible for the full fee.

Acceptance Agreement

I understand and agree with the above financial policy. I also understand that I am responsible for knowing my insurance benefits, maximums, covered and non-covered services, frequencies, etc. and are responsible for **ALL FEES** for me or my dependent children regardless of insurance coverage and payments. I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me.

ALL PRODUCTS SOLD ARE FINAL SALE, NO REFUNDS, NO EXCHANGES.

Broken or Late Cancellation appointment fees

I am aware that I must give 24 hour notice if I am unable to keep my appointment. If a 24 hour notice is not given or if I do not show up for my appointment, we reserve the right to charge a **$35 fee** (which is not covered by your insurance company or Medicaid) and must be paid prior to your next appointment. We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Scheduling Appointments of 2 hours or more

All appointments equaling a total of 2 hours or more on one day will require a **$100 deposit one week prior** to appointment date. Deposit will go toward copay. If copay for services is less than $100, the full copay will be considered as the required deposit.

x _____ Date: _____

Signature of Patient or Parent/Guardian if a Minor

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date:_____Patient Name:_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records

Name:_____ Relationship:_____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

❑ Cell Phone Confirmation
❑ Home Phone Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

❑ Cell Phone Confirmation
❑ Home Phone Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

❑ Phone Message
❑ **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____
Please ***print*** name of Patient Please ***sign*** Patient / Guardian of Patient

_____ _____
Legal Representative / Guardian Relationship of Legal Representative / Guardian

OFFICE USE ONLY
As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❑ It was emergency treatment
❑ The patient refused to sign
❑ The patient was unable to sign because
❑ I could not communicate with the patient
❑ Other (please describe)_____

Signature of Privacy Officer _____

Updated Medical History 2016

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you need to premedicate for any reason? (for example: for a joint replacement, valve replacement, or past history of	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	
Are you taking any blood thinning medications?	○ Yes ○ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Do you use controlled substances?	○ Yes ○ No	If yes
Other?	☐	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
Yellow Jaundice ○ Yes ○ No			

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____