



RUTLEDGE
DENTAL ASSOCIATES
Family and Cosmetic Dentistry

Please provide the following information for your child:

Name: _____ DOB: _____

Mother's Information:	Father's Information:
Name: _____	Name: _____
DOB: _____	DOB: _____
<input type="checkbox"/> Mother <input type="checkbox"/> Step Mother <input type="checkbox"/> Guardian Has legal custody of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Father <input type="checkbox"/> Step Father <input type="checkbox"/> Guardian Has legal custody of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No
Address (if different): _____ _____	Address (if different): _____ _____
Cell: _____	Cell: _____
Home: _____	Home: _____
Work: _____	Work: _____

We understand there are times your child may come with someone other than a parent or guardian. Please provide their information below. By providing their information you are giving us consent to provide information about your child's dental health and care to this individual.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

By signing below you agree that you have provided the most up to date and correct information to the best of your knowledge. You also agree to the following:

- ❖ That the patient will attend all dental visits with their mother, father, or authorized adult listed above. If the patient comes to the appointment without an adult the appointment may be cancelled.
- ❖ For the safety of the patient and accompanying adult, the individual waiting for the patient will wait in the designated waiting areas.
- ❖ The accompanying adult is responsible for payment at the time of service.

Signature: _____ **Date:** _____

Insurance Information

Primary Dental Insurance: _____

ID # _____ Group # _____

Policy Holder*: _____

Policy Holder DOB: _____ Social Security # _____

Home Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Policy Holder Occupation: _____

Employer's Address: _____

Secondary Dental Insurance: _____

ID # _____ Group # _____

Policy Holder*: _____

Policy Holder DOB: _____ Social Security # _____

Home Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Policy Holder Occupation: _____

Employer's Address: _____



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

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

Cell Phone Confirmation Work Phone Confirmation
 Home 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:

PhoneMessage **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 _____

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