Munson Dental and Facial Aesthetics

Patient Information

Please circle one: Dr/Mr/Mrs/Ms/Miss

First:	Middle:	Last: Jr/Sr:
Address:	City:	State: Zip:
Home Phone:	Cell Phone:	Email:
Patient Social Security Number:	Date of Birth:	Sex: **M / F**
Emergency Contact:	Phone:	

Primary Dental Insurance	**Secondary Dental Insurance**
Subscriber Name:	Subscriber Name:
Subscriber SSN: DOB:	Subscriber SSN: DOB:
Relationship to Subscriber: Self/Spouse/Child/Other	Relationship to Subscriber: Self/Spouse/Child/Other
Employer Name:	Employer Name:
Insurance Company:	Insurance Company:
Claims Address:	Claims Address:
ID # Group #	ID # Group #
Insurance Phone:	Insurance Phone:

Payment Policy:

Our office depends on reimbursement from insurance as well as the patient for the costs of services.
As a courtesy to you, we file all insurance claims to ensure you get the benefits that you are entitled to.
Your ***estimated financial responsibility*** for all procedures will be determined and given to you upon scheduling. This ***ESTIMATE*** is due, along with your deductible, at the time of service. As a condition of our office, all financial arrangements must be made in advance.
A grace period of 60 days will be given for any outstanding balance upon your account. After 60 days a 1.5% interest fee will be added to your overdue balance each month. ***Patients are responsible for amounts not covered by insurance, as well as claims not paid within 90 days.*** In the event your account is turned over for collection, additional fees will be charged based upon your balance.
There is a $50.00 fee on all returned checks.

I have read and understand, I am financially responsible for all charges:

Signature: **Date:**

Relationship to Patient: ____

PATIENT DENTAL HEALTH

Patient Name: Date Of Birth:
Why have you come in to see us today? (e.g.: pain, checkup, etc.)
Previous Dentist: Date of last cleaning:
What problems have you had with past dental treatment?
Are you nervous about seeing a dentist? □ Yes! □ No If yes, please tell us why:
How often do you brush? Do you floss? □ Yes □ No How often?

(please circle Y or N for each)

Y N I clench or grind my teeth during the day or while sleeping	Y N My gums feel tender or swollen
Y N My gums bleed while brushing or flossing	Y N I have problems eating
Y N I like my smile	Y N I have had orthodontics
Y N I'd like to improve my smile	Y N I have had a facial or jaw injury
Y N I avoid brushing part of my mouth due to pain	Y N I want my teeth whiter

PATIENT MEDICAL HISTORY

Do you or have you had any of the following? Please circle Y for yes or N for no.

Y N Heart disease or conditions
Y N Heart murmur/mirtal valve prolapse
Y N Stroke
Y N Congenital heart lesions
Y N Rheumatic fever
Y N High or low blood pressure
Y N Anemia or blood disorder
Y N Pacemaker
Y N Prolonged bleeding disorder
Y N Tuberculosis or lung disease
Y N
Asthma
Y N Seasonal allergies
Y N Sinus trouble
Y N Snoring/Sleep apnea
Y N Epilepsy/Seizures
Y N Ulcers
Y N Liver disease
Y N Jaundice
Y N Hepatitis Type ______
Y N Diabetes
Y N Excessive urination/Thirst
Y N Infectious mononucleosis
Y N Herpes
Y N Arthritis
Y N Sexually transmitted disease
Y N Kidney disease

Y N Tumor or malignancy
Y N Cancer/Chemotherapy
Y N Radiation treatment
Y N History of drug addiction
Y N Implants/Artificial Joints: □ Hip □ Knee □ Other ____________________
____
Y N I have had major surgery: Year _________
Type of Operation ___________________________________

Y N Aids
Y N Immune suppressed disorder
Y N Hearing loss
Y N Fainting spells
Y N Glaucoma
Y N History of emotional/Nervous disorder
Y N Smoke or use tobacco
How much per day ______ Years ______
Y N I have consumed alcohol in the last 24 hrs
Y N I usually take an antibiotic prior to dental treatment

Y N Thyroid trouble
Y N Heart valve replacement
Y N Vascular graft

Are you allergic to any of the following?

Y N Aspirin
Y N Ibuprofen
Y N Sulfa drugs/Sulfites/Sulfides
Y N Antibiotics
Y N Codeine
Y N Latex, metals, plastics
Y N Local anesthetics (Novocaine)
Y N Other medications? ________________

Please list all medications you are taking

____
____

Women

Y N Are you taking birth control medications

Y N Are you or could you be pregnant or nursing

Signature ____ Date ________________________________

Relationship to patient: ____

CONSENT TO DENTAL TREATMENT

Patient Name: ___________________________

Please read carefully, initial each line and sign below

__________ I do authorize and give consent to Dr. Cain, Dr. Morris and/or such other staff as they may appoint, to perform or assist in the performance of dental treatment or procedures. I understand that the purpose of any procedures is for treatment.

__________ I consent to the administration of any anesthetic that the dentist deems necessary to provide proper treatment. I understand that the use of medications, anesthetics and some procedures embody a certain risk.

__________ I acknowledge that no guarantee has been given or implied by anyone as to the results that may be obtained.

__________ I understand that during procedures, unforseseen conditions may arise that necessitate different procedures from those planned. I consent to the performance of additional procedures that are deemed necessary in the professional judgment of the dentist, and I understand that payment for these additional procedures is my responsibility.

__________ As an alternative to any procedure, I may elect to refuse treatment.

__________ I also understand that failure to treat a condition will result in a non-treated outcome.

__________ I consent to the disposal of any tissues or body parts that may be removed.

__________ The attached medical and dental history was completed fully and accurately to the best of my knowledge.

__________ I grant my permission to you or your assignees to telephone me at home or at my work to discuss matters related to this consent, my treatment or my account.

__________ I have been given an opportunity to refuse to consent to any and all treatment or procedures specified in this form and have indicated my exclusion by drawing a line through the objectionable word(s), sentence(s), or paragraph(s), and writing my initials next to the portion to which I refuse to consent. I am also free to indicate at the end of this form anything not mentioned herein, but to which I refuse consent.

I certify that I have read and understand all the above. I accept all risk, if any, in of obtaining the desired beneficial results. I acknowledge that the dentist has explained all of the above to me in a manner to allow me to comprehend the consequences of my actions. Any questions about treatment and its attendant risks have been answered fully and to my complete satisfaction.

Signature: ______________________________ Date: ______________________

Relationship to patient: ______________________________

Munson Dental and Facial Aesthetics

4811 Munson St NW Canton, OH 44718

Financial Policy

Thank you for choosing us for all of your dental needs. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

1. Cash, Check, Visa, Mastercard, Discover
2. We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to appointment for treatment plans of $300.00 or more.
3. In-Office payment plan-we will spread your balance of $500 or more over 3 monthly payments **with a credit card on file in our office.** A payment will automatically be posted to your card on the 15th of each month.

Please note:

Our dental practice requires payment at the time of treatment. The payment will be collected upon checkout.

We will file your insurance to help you receive the maximum allowance your company offers.
PLEASE NOTE: ***Regardless of insurance, you are ultimately responsible for the entire fee.***

There will be a charge of $50.00 for returned checks.

A 1.5% monthly interest charge will be assessed to all delinquent accounts over 60 days.

If you have any questions, please do not hesitate to ask. We are here to help you get the treatment you want and need.

I understand that any insurance coverage estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon myself or my dependents in this dental office. Any insurance claim not paid in full after 90 days will become my responsibility to pay at that time.

____

Patient, Parent or Guardian Signature Date

____

Patient Name (Please Print)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I ____have read/received a copy of this office's Notice of Privacy Practices.

Print Name: ____

Sign: ____

Date: _______________________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _________________

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 4/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the 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 Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operation include 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 operation, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an 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 a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described 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 agree that we may do so.

Persons Involved In Care: We may use or disclose health 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 disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by law: We may use or disclose your health information when we are required to do so by law.

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 threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official health information required for lawful intelligence, counterintelligence, and other nation security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at 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 practicably do so. (You must make a request in writing to obtain access to your health 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 requst copies, we will charge you $____ for each page, $____ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that 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 disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional request.

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

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handeled under the alternative means or location you request.

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

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

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

If you are concerned that we may have 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 use or disclosure of your health information or to have us communicate with you by alternative means or at alternative location, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint 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 Heath and Human Services.

Contact Officer: Stefanie Cain Nikodem, D.D.S.

Telephone: (234) 215-2735 Fax: (234) 215-2738

Patient Authorization to Release Confidential Information

(to family members and/or caretakers)

I, ____, hereby request and authorize the staff at **Munson Dental and Facial Aesthetics** to discuss and disclose any and all clinical treatment information concerning my care to:

____
Name/Relation

____
Name/Relation

____
Phone **Phone**

These records include, but are not limited to: personal patient information, medical and dental histories, examination records, radiographs, clinical photographs, treatment plans, treatment records, referral and consultation recommendations and reports, diagnostic models, charges and fees, insurance, and other relative materials.

I expressly release from liability the above named person or entity from any and all liability arising from the compliance of this request and disclosure of the requested information.

Signed:____ **Date:**_______________________

This does not apply to me at this time.

Signed:____ **Date:**_______________________