FORT MITCHELL DENTISTRY

Dr. Reuben Moyana
1095 Highway 165, Ste D
Ft. Mitchell, AL 36856
334-855-3300

PLEASE COMPLETE ALL INFORMATION THAT APPLIES TO YOU - THANK YOU

PATIENT LAST NAME: _____ **FIRST:** _____ **INITIAL:** _____

How do you wish to be addressed? _____ DOB _____

(❑ Single ❑ Married ❑ Divorced) (❑ Male ❑ Female) Full time Student? ❑ Yes ❑ No School _____

Address _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Employer _____ Occupation _____

Soc. Sec. No. _____ Dental Insurance Co. _____ Group _____

Is patient covered by another dental insurance? ❑ Yes ❑ No Insurance Co. _____

How did you hear about our practice? Whom may we thank for your referral? _____

HUSBAND, FATHER OR RESPONSIBLE PARTY (IF OTHER THAN PARENT)

Last Name _____ First _____ Initial _____

Address _____ DOB _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Employer _____ Occupation _____

Soc. Sec. No. _____ Dental Insurance Co. _____ Group _____

WIFE, MOTHER OR RESPONSIBLE PARTY (IF OTHER THAN PARENT)

Last Name _____ First _____ Initial _____

Address _____ DOB _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Employer _____ Occupation _____

Soc. Sec. No. _____ Dental Insurance Co. _____ Group _____

NEAREST RELATIVE

Last Name _____ First _____ Initial _____

Address _____

City _____ State _____ Zip _____ E-Mail _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

AUTHORIZATION

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits **may pay less** than the actual bill for services. I understand **I am financially responsible** for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer.

I attest to the accuracy of the information on this page.

Signature _____ Date _____

OFFICE USE ONLY

INSURANCE VERIFICATION

PHOTOCOPY AND PLACE
FRONT SIDE OF DENTAL CARD HERE

PHOTOCOPY & PLACE
BACK SIDE OF DENTAL CARD HERE

BENEFIT BREAKDOWN

_____ % Diagnostic – Freq.

FMX Freq. ❑ Class I ❑ Class II

BWX Freq. ❑ Class I ❑ Class II

_____ % Preventative Freq.

_____ % Restorative

_____ % Endodontics

_____ % Periodontics

_____ % Pros. Removal

_____ % Implants

_____ % Pros. Fixed

_____ % Oral Surgery

_____ % Orthodontics - Age _____

_____ % Adjunctive Gen Svc/Nitrous

_____ % Single Crowns – ❑ Basic ❑ Major

_____ % Sealants Age: _____ Freq: _____

_____ % Fluoride Age: _____ Freq: _____

_____ **Benefit Maximum (*required)**

_____ **Ortho Maximum (*required)**

BENEFIT BREAKDOWN

Plan Type: ❑ Capitation Plan ❑ PPO ❑ Traditional ❑ Premier

Fee Schedule: _____ ***required***

Deductible Applies To: ❑ Class I ❑ Class II ❑ Class III ❑ Class IV

Individual Deductible: _____

Family Deductible: _____

Prosthetic Replacement: ❑ Yes ❑ No

If Yes, How Long?: _____

Waiting Period: ❑ Yes ❑ No

If Yes, How Long?: _____

NOTES

Dental & Medical History

PLEASE COMPLETE ALL INFORMATION – THANK YOU!

PATIENT LAST NAME: _____ **PATIENT FIRST NAME:** _____

DENTAL HISTORY

Reason for today's visit: _____ Date of last dental visit: _____

Former dentist: _____ Date of last dental x-rays: _____

Please check if you have/had:

- Bad breath ☐
- Blisters on lips or mouth ☐
- Burning sensation on tongue ☐
- Chew on one side of mouth ☐
- Cigarette, pipe, or cigar smoking ☐
- Smokeless tobacco ☐
- Dry mouth ☐
- Food collection between teeth ☐
- Clench teeth ☐
- Grind teeth ☐
- Growths or sore spots in mouth ☐
- Gums swollen, tender, or bleeding ☐
- Head, neck, or jaw pain or aches ☐
- Lip or cheek biting ☐
- Loose teeth or broken fillings ☐
- Mouth breathing ☐
- Orthodontic treatment ☐
- Nitrous Oxide ☐
- Periodontal treatment ☐
- Sensitivity to pressure or irritants (cold, heat, sweets) ☐

How often do you floss? _____

How often do you brush? _____

Have you ever had an allergic reactions to Novocaine, local or general anesthetics? ☐

If Yes, please explain:

_____

Have you had trouble from previous dental care? ☐

If Yes, please explain what happened:

_____

_____

MEDICAL HISTORY

Physician's name: _____ Date of last visit: _____

Physician's address: _____

Have you ever had a blood transfusion? Yes ☐ If Yes, please describe: _____

Have you had any serious illnesses or operations? Yes ☐ If Yes, please give approximate dates: _____

Pregnant? Yes ☐ Due Date? _____ Nursing? Yes ☐ Birth Control Pills? Yes ☐

Please check if you have/had:

- Allergies, hay fever, sinusitis ☐
- Anemia ☐
- Arthritis, Rheumatism ☐
- Artificial Heart Valves ☐
- Artificial Joints ☐
- Asthma ☐
- Asthma: Required Hospitalization ☐
- Asthma: Used Steroids ☐
- Bleeding abnormally with operation/surgery ☐
- Blood Disease, Clotting Disorders ☐
- Cancer ☐
- Chemical Dependency ☐
- Chemotherapy ☐
- Circulatory Problems ☐
- Cortisone Treatments ☐
- Cough, persistent or bloody ☐
- Diabetes ☐
- Emphysema ☐
- Epilepsy ☐
- Fainting ☐
- Glaucoma ☐
- Headaches ☐
- Heart Murmur ☐
- Heart Problems ☐
- Hepatitis? ☐

Type: _____

- Herpes ☐
- High Blood Pressure ☐
- Any Immune Deficiency (incl. HIV/AIDS) ☐
- Jaundice ☐
- Kidney Disease ☐
- Low Blood Pressure ☐
- Mitral Valve Prolapse ☐
- Osteopenia ☐
- Osteoporosis ☐
- Pacemaker ☐
- Radiation Treatments ☐
- Respiratory Disease ☐
- Rheumatic Fever ☐
- Scarlet Fever ☐
- Shortness of Breath ☐
- Sinus Trouble ☐
- Sickle Cell Anemia ☐
- Skin Rash ☐
- Stroke ☐
- Swelling of Feet/Ankles ☐
- Thyroid Problems ☐
- Tonsillitis ☐
- Tuberculosis ☐
- Tumor or Growth on Head/Neck ☐
- Ulcer ☐
- Venereal Disease ☐
- Weight Loss, Unexplained ☐
- Do you wear contact lenses? ☐
- Do you consume alcoholic beverages? ☐
- Are you currently under the care of a Physician? ☐
- Are you allergic/sensitive to Latex? ☐
- Allergic to penicillin, Aspirin or Other Drugs? ☐

If Yes, please specify:

_____

_____

Are you currently taking any Medications? ☐

If Yes, please list:

_____

_____

_____

_____

_____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature: _____ Date: _____

Reviewed by: _____ Date: _____

Dental & Medical History

EDICAL HEALTH HISTORY – UPDATE AND EXCEPTIONS

ave read my medical history and confirm that it adequately states past and present conditions

DATE	EXCEPTIONS	NONE	PATIENT INITIALS	REVIEWED BY

SECTION A: PATIENT GIVING CONSENT

Patient Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read the Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Compliance Officer: **Dr Reuben Moyana**
Telephone: **334-855-3300**
Address: **1095 Highway 165, suite D**
Fort Mitchell, AL 36856

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation.

SECTION C: SIGNATURE

I, _____ have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

SECTION D: 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
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (please specify) _____

Signature: _____ Date: _____

08/2016

You are entitled to a copy of this consent after you sign it.

PRIVACY PRACTICES RECEIPT / CONSENT FORM

SECTION E: REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

If this Revocation of Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

SECTION F: PATIENT/RELATIVE HIPAA CONSENT

I, _____ , understand that by signing this Consent form, I am giving my consent to Fort Mitchell Dentistry Centers to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations with the following family member:

Name: _____

Relationship: _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Compliance Officer listed on Section B.

_____ _____

Patient's Signature (Legal Guardian, if Patient is a minor) Date:

SECTION G: RESTRICTION OF PROTECTED HEALTH INFORMATION (PHI)

I request Fort Mitchell Dentistry to restrict the disclosure of my PHI to those specified below:

Name: _____

Name: _____

Signature: _____ Date: _____

If this Restriction of PHI is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Financial Policy at Ft. Mitchell Dentistry

PATIENT NAME: _____ _____ **DATE:** _____

Please understand that Fort Mitchell Dentistry, (Reuben Moyana DMD, P.C are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- **ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING THE DENTAL PROFESSIONAL.**
- **FULL PAYMENT IS DUE AT TIME OF SERVICE.**
- **WE ACCEPT CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER AND CARE CREDIT.**
- **We PROVIDE INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT PORTION OF PARTICULAR DENTAL SERVICE(S) IS ESTIMATED AND DUE AT THE TIME OF SERVICE.**

ADULT PATIENTS

Adult patients are responsible for full payment at time of service.

MINORS ACCOMPANIED BY AN ADULT

The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

UNACCOMPANIED MINORS

The parents or guardians are responsible for full payment at time of service. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, or to Visa, Master Card or Discover. We do not accept American Express payments for visits by unaccompanied minors.

INSURANCE

FMD provides insurance company billing as a *courtesy* to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by **FMD** staff regarding his/her remaining benefit in any such benefit period.

The claims we submit to insurance companies indicate that you have assigned those benefits to FMD. However, if you are paid by the insurance company instead of FMD you then become responsible for the total account balance and payment would be expected immediately.

If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available.

You as a patient are always responsible for any charges that are not covered by your insurance.

MEDICARE/ MEDICAID/ CHAMPUS/ WORKER'S COMPENSATION

If you are covered by Medicare, Medicaid, Champus, Worker's Compensation or any other government sponsored program, please discuss your payment situation with our office staff prior to arriving at the FMD office on the date of service.

DELINQUENT PAYMENTS

It is our policy to charge finance fees at 1.5% for outstanding patient balances after the balance has been outstanding 30 days. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of $25.00.

MISSED APPOINTMENTS

Unless cancelled at least 48 hours in advance, our policy is to charge for missed appointments at the rate of $35.00 per each 30 minutes of missed appointment time. Please help us service you better by keeping scheduled appointments.

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature _____ **Date** _____