Welcome to Honeygo Village Dentistry!

Thank you for your visit today! We appreciate you trusting us to care for your dental health, and are pleased to welcome you to our practice. To help us serve you better, please take a few moments to full out the following form as completely as you can. If you have any question, just ask – we will be happy to help. We look forward to working with you!

Patient Information

Date ____________ Home Phone ____________________ Cell Phone ________________________

Name __________________________ Social Security # _____________ Work Phone ___________

Address ______________________________ City _____________ State _____ Zip ___________

Sex __male __female Age___ Date of Birth___________ Single___ Married ___ Widowed___ Divorced ___

Employer _________________________ Business Phone ______________ Occupation __________

Business Address ____

May we ask your e-mail address? ____

Whom may we notify in case of an emergency? __________________________ Phone____________

Whom may we thank for referring you? ____

Primary Insurance

Who carries the insurance in your family? ____

Name__________________________ Relationship to patient ____________ Phone ____________

Address (if different from patient's) ____

Employed by ______________________________________ Work Phone __________________

Business Address ______________________________ Employee/Subscriber # __________________

Insurance Company___________________ Group #__________ Phone ____________________

Secondary Insurance – **Please be advised that although we will be happy to assist you in filing your secondary insurance, you *will be reimbursed by your insurance after paying us directly.***

Person who carries secondary insurance______________________ Relationship________________

Address ____ Phone ____________________

Social Security #_______________ Subscriber/Employee #__________ Date of Birth ____________

Insurance Company________________________ Group #___________ Phone ________________

(Please continue on the other side)

Dental Health History

Reason for today's visit____

Previous Dentist ______________________ Address ______________________

Date of last dental visit______________________ Last x-rays______________________

Please indicate if you have had a problem with any of the following conditions:

____ Bad Breath
____ Bleeding Gums
____ Clicking or Popping Jaw
____ Food collection between teeth
____ Grinding Teeth
____ Loose teeth / Broken Fillings
____ Periodontal "gum" Problems
____ Sores or growths in mouth
____ Sensitivity to Hot or Cold
____ Sensitivity to Sweets
____ Sensitivity to Biting
____ Other

Are you thinking about changing the overall appearance of your teeth? If so, how?__________

______________________________________ How often do you floss?______________

Medical History

Physician's name ______________________________ Date of last visit ______________

Previous hospitalizations, illnesses, or operations____

____

Ladies: Are you pregnant ___yes ___no Nursing? ___yes ___no Taking Birth control? ___yes ___no

Has your physician ever told you to be premedicated with antibiotics prior to any dental treatment? _____**yes** ____**no**

Please check if you have or have had any of the following conditions:

___ AIDS
___ Anemia
___ Arthritis
___ Artificial Heart
___ Artificial Joints
___ Asthma
___ Back Problem
___ Blood Disease
___ Cancer
___ Chemotherapy
___ Circulatory Problems
___ Cortisone Treatments
___ Cough, Persistent
___ Cough up Blood
___ Diabetes
___ Epilepsy
___ Fainting
___ Glaucoma
___ Headaches
___ Heart Murmur
___ Heart Problems
Describe____________
___ Hemophilia
___ Hepatitis
___ High Blood Pressure
___ HIV
___ Jaw Pain/clicking
___ Kidney Disease
___ Liver Disease
___ Mitral Valve Prolapse
___ Nervous Problems
___ Pacemaker
___ Psychiatric Care
___ Radiation Tx
___ Recreational Drugs
___ Respiratory Disease
___ Rheumatic Fever
___ Shortness of Breath
___ Skin Rash
___ Stroke
___ Swelling of Feet/ankles
___ Thyroid Problems
___ Tobacco Habit
___ Tonsillitis
___ Tuberculosis
___ Ulcers
___ Venereal Disease

Please list any medications you are currently taking____

Please list all allergies____

Authorization

I have reviewed this questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment, and I agree to notify the dentist if any change in my health status should occur.

I authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize use of this signature on all Insurance submissions.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

Signature______________________________ **Date**______________________

(Parents please sign if patient is a minor)

PAYMENT IS DUE IN FULL AT TIME OF SERVICE UNLESS ARRANGEMENTS HAVE BEEN APPROVED

(Please continue on to next page)

Responsibility for Balance

I understand that I am responsible for any balance incurred for any dental services rendered by any dental provider in this office, regardless of estimated insurance benefits. I understand that any estimate given to me regarding my insurance coverage or dental treatment is just an estimate and subject to change when reviewed by my insurance company. I understand that my insurance, if I carry insurance, can change, deny, or recode any dental treatment according to their contracts with my employer.

Signature________________________________ **Date** ______________
(Parent's Signature if Minor)

Insurance Assignment of Benefits

I hereby authorize payment of any dental benefits issued by my insurance company directly to Dr. Stephen R. Feit.

Insured's Signature______________________________________

Consent to treatment

I request and authorize Dr. Stephen Feit, and/or such other persons as he appoints, to perform or assist in the performance of needed dental treatment. I understand that this is for the purpose of, but not limited to, one of the following: diagnosis, pain, decay, periodontal disease or treatment, restorable, or non-restorable teeth, and any other conditions of the mouth. I further consent to any needed x-rays, medications, or referrals that might be necessary to correctly diagnose or treat my condition. I consent to, and authorize the performance of, any additional care, procedure, or treatment not specified above that the dentist believes necessary, as a result of unforeseen events or conditions. I understand that there have been no guarantees given or implied of any sort by anyone as to the results that may be obtained. I consent to the administration of any anesthetic deemed necessary and I understand the risks, including but not limited to, bruising, swelling, temporary or permanent numbness, sensitivity reaction, etc. I have been given the opportunity to refuse to consent to any and all treatments proposed by not signing this document or by resending this signature in writing, at any time. I understand that this is a general consent form and that I may be required sign more specific consent forms based on the treatment that is proposed. I understand that my consent to dental treatment is also a consent to dental charges for which I am fully responsible. I certify that I have read and understand the above; I accept all risk in the hope of obtaining the desired beneficial results.

Signature______________________________________ **Date**____________
(Parent's signature if minor)

(Please continue to final consent sheet)

Please detach the bottom portion for your records

Method of Payment

1. **Payment is due at time of service. If you have dental insurance, you will be responsible for your co-payment and deductible (if any) at time of service. Should you not be prepared to pay your entire balance at time of treatment, please advise the staff PRIOR to treatment so that financial arrangements can be completed.**
2. We accept cash, check, money orders, debit cards, Master Card, Visa, American Express, or Discover for payment.
3. For larger treatment plans, 3rd party financing including CareCredit, Dental Fee Plan, and Citi Health Card may be available to you through this office. Please speak with the Office Manager for more information concerning these options.

Dental Insurance

1. **Your dental insurance is a contract between you, your employer, and your insurance company.** As a courtesy, we will submit your dental claims to your insurance company. **You will be responsible for your estimated co-payment and deductible at time of service. (This is only an ESTIMATE which may vary when we receive payment from your insurance company.) If your claim has not been paid within 90 days of submission by this office, you will be responsible to pay the balance of the claim.** We will assist you, to the best of our ability, in being reimbursed by the insurance company for that payment.
2. **Not all treatments are a covered expense by your insurance.** We will do our best to maximize your insurance benefits and minimize your out-of-pocket expense.

Related Financial Information

1. **Returned checks will result in a $35.00 charge to your account.**
2. **In the event that the account is not paid and we refer the account to a collection agency, you will be responsible for all fees incurred for the collection of your bill (i.e. attorney fees, court costs, and the collection agency fees).**
3. Your appointment time is reserved exclusively for you. **Any change in your appointment affects many patients, thus, a 24 hour notice is required. Anything less than a 24-hour notice is subject to a $35 per ½ hour missed appointment fee that will be levied at the discretion of the staff.**

I have read and understand the above information. I understand that I am responsible (regardless of my insurance) for any charges or fees incurred from services rendered.

Signature ____

(Please continue on other side)

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: ____________________ Signature: ____________________ Date: __________

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.