ROBERTSDALE DENTAL CARE

About You

Today's Date:_____

Name:_____ I prefer to be called: _____
Last First M.I.

Birthdate:_____/_____/_____ S. S. #:_____-_____-_____ Drivers License: _____
State Number

Street Address: _____
and Street City State Zip
Mailing Address: _____
P. O. Box City State Zip

Home Phone #_____ Work #_____ Cell/Pager # _____

We email birthday coupons! Email Address:_____

How did you find out about our office?_____

What pharmacy do you use?_____

Employer & Address:_____ Occupation: _____

Spouse:_____ Birthdate:_____/_____/_____ Employer: _____

Emergency Contact Person: _____

Relation:_____ Home Phone # _____

Address: _____
P. O. Box/Street City State Zip

Person Responsible for Account

Name:_____ Relationship:_____ S. S. #:_____-____- _____

Address: _____

Home Phone #:_____ Work Phone #: _____

Insurance Information

We will file your insurance on your behalf as a service to you. There is no guarantee of payment. Please check below what type of insurance you have.

☐ Dental Insurance Name of Insurance: _____ ☐ Medical Insurance Name of Insurance: _____

I understand that payment is my obligation regardless of insurance or any other third party involvement.

Signature:_____ **Date:** _____

ROBERTSDALE DENTAL CARE

Patient Name _____

Medical History

Do you have a personal physician? ☐ Yes ☐ No Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Physician's Name: _____ Date of Last Visit: _____ Phone #: _____

Are you currently under the care of a physician? ☐ Yes ☐ No Please explain: _____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No Have you ever been involved with dental/medical legal activity? ☐ Yes ☐ No

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Sedatives
Y	N	Barbiturates	Y	N	Jewelry	Y	N	Sulfa Drugs
Y	N	Codeine	Y	N	Latex	Y	N	Tetracycline
Y	N	Dental Anesthetics	Y	N	Penicillin	Y	N	Other

Please list additional drugs that cause allergic reactions: _____

Are you taking any of the following?

Y	N	Acetaminophen	Y	N	Blood Pressure Medication	Y	N	Recreation Drugs
Y	N	Antibiotics	Y	N	Cold Remedies	Y	N	Steroids/Cortisone
Y	N	Antihistamines	Y	N	Digitalis/Heart Medication	Y	N	Thyroid Medicine
Y	N	Aspirin	Y	N	Insulin/Diabetes Drugs	Y	N	Tranquilizers
Y	N	Blood Thinners	Y	N	Nitroglycerin	Y	N	Other

Are you taking any prescription/over-the-counter drugs not listed above? _____

Do you have or have you experienced any of the following?

Y	N	Abnormal Bleeding	Y	N	Alcohol Abuse	Y	N	Arthritis	Y	N	Liver Disease
Y	N	Artificial Valves	Y	N	Asthma	Y	N	Blood Transfusion	Y	N	Radiation Treatment
Y	N	Chemotherapy	Y	N	Colitis	Y	N	Congenital Heart Defect	Y	N	Sinus Problems
Y	N	Difficulty Breathing	Y	N	Drug Abuse	Y	N	Emphysema	Y	N	Ulcers
Y	N	Fainting Spells	Y	N	Glaucoma	Y	N	Headaches	Y	N	Fatigue
Y	N	Heart Murmur	Y	N	Heart Surgery	Y	N	Hepatitis	Y	N	Lack of motivation
Y	N	HIV+/AIDS	Y	N	Hospitalized	Y	N	Kidney Problems	Y	N	Excessive sleepiness
Y	N	Low Blood Pressure	Y	N	Pacemaker	Y	N	Mitral Valve Prolapse	Y	N	Anxiety/Depression
Y	N	Rheumatic Fever	Y	N	Scarlet Fever	Y	N	Seizures	Y	N	Loud snoring
Y	N	Stroke	Y	N	Thyroid Problems	Y	N	Tuberculosis (TB)	Y	N	Morning headaches
Y	N	Artificial Bones/Joints	Y	N	Cancer	Y	N	Diabetes	Y	N	Difficulty concentrating
Y	N	Epilepsy	Y	N	Heart Attack	Y	N	High Blood Pressure	Y	N	Night-time sweating

Y N Counseling for excessive use of alcohol and/or prescribed drugs?

Y N Surgery What kind?: _____

Has any doctor recommended pre-medication with antibiotics before dental appointments for any reason? If so, please explain:

_____

Please list any serious medical condition(s) you have experienced: _____

Authorizations

I affirm that the information I have given is correct to the best of my knowledge. It will be held in strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

Patient Signature _____ Date _____

Doctor Signature _____ Date _____

ROBERTSDALE DENTAL CARE

FINANCIAL POLICY

All Patients

_____ Robertsdale Dental Care requests at least 24 hours notice in order to reschedule or cancel my appointment. Failure to give 24 hours notice will result in a $50 missed appointment fee.

_____ Robertsdale Dental Care will call the day prior to confirm my appointment. If they are unable to confirm my appointment after trying every contact method I've provided, I understand that they may release my appointment to another person.

_____ I understand that payment for treatment is due at the time treatment is rendered. Depending on the cost of the treatment, payment may be requested prior to the start of treatment. Payment for sedation surgery needs to be paid in full prior to scheduling.

_____ I understand that if I have no insurance coverage, I am responsible for the payment for services provided for myself or my dependents.

_____ Robertsdale Dental Care accepts cash, check, Visa, MasterCard, Discover and American Express. Please be aware there is a $30.00 service fee for all returned checks. Robertsdale Dental Care also participates with the Worthless Check Unit. Monthly payment plans are available with no interest through Care Credit.

_____ I understand that in the event my account is turned over to collections or for legal judgment or action, I am responsible for all reasonable attorneys' fees, court costs and associated costs with collections.

Patients with Insurance

_____ I understand that as a courtesy to me and upon my authorization, Robertsdale Dental Care will submit a claim to my primary and secondary dental insurance upon completion of treatment. I authorize payment(s) to go directly to Dr. W. Jason Northcutt. If I have a third insurance, it is my responsibility to file to that policy.

_____ Robertsdale Dental Care is a preferred provider (in network) of Blue Cross Blue Shield of Alabama. Although Dr. W. Jason Northcutt is considered an out of network provider to other private insurance companies, Robertsdale Dental Care is willing to file your claim if benefits are available.

_____ I understand that Robertsdale Dental Care does not file to Medicare or Medicaid.

_____ **Treatment plans are an estimate only based on information given from your insurance company. Upon final settlement of the insurance claim, any and all amounts of non-covered or denied services will be billed directly to me** by Robertsdale Dental Care. I am responsible for contacting my insurance company regarding any disputes/discrepancies in payment.

_____ I understand that since certain Delta Dental insurance reimburses the patient and not the provider, payment may be due in full at the time of appointment.

_____ _____

Signature of Patient or Responsible Party Date

In the case of a minor, the individual that signs this document is responsible for payment.

Please let us know if you have any questions regarding our financial policy.

ROBERTSDALE DENTAL CARE

Privacy Agreement

Dr. Northcutt, Associates and Staff (collectively labeled Dentist) agree to maintain Privacy of our patients as outlined in this HIPAA form. The Dentist takes pride in being able to extend a greater degree of privacy than is required by HIPAA, state confidentiality mandates, and common law.

Federal and State Privacy laws are complex. Unfortunately, some dental offices try to find loopholes around these laws. For example, HIPAA forbids dentists from receiving money for selling lists of patients or protected health information to companies to market their products or services directly to patients without authorization. Some dental practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Dentist believes this is improper and may not be in the patient's best interest. Accordingly, Dentist agrees not to provide any list for marketing directly to patients. Regardless of legal privacy loopholes, Dentist will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

In consideration for treatment and the above noted patient protection, Patient agrees to refrain from directly or indirectly publishing or airing commentary upon Dentist and his practice, expertise and/or treatment unless explicitly mandated by law. Publishing is intended to include attribution by name, by pseudonym, or anonymously. Dentist has invested significant financial and marketing resources in developing the practice. In addition, Patient will not denigrate, defame, disparage, or cast aspersions upon the Dentist: and (ii) will use all reasonable efforts to prevent any member of their immediate family or acquaintance from engaging in any such activity. Published comments on web pages, blogs, and/or mass correspondence, however well intended, could severely damage Dentist's practice.

Your visit with the Dentist may be recorded for training purposes. The tape will be securely stored and is subject to the same degree of confidentiality as your medical records. You do not have to agree to your visit with the doctor being recorded. If you do not want your visit to be recorded, please tell Reception. This is not a problem, and will not affect your visit in any way.

Dentist feels strongly about Patient's privacy as well as the practices' right to control its public image and privacy. Both Dentist and Patient will work to prevent the publishing or airing of commentary about the other party from being accessed via Internet, blogs, or other electronic, print, or broadcast media without prior written consent. Finally, this agreement shall be in force and enforceable (and fully survive) for a period of the longer of (a) five years from Dentist's last date of service to Patient; or (b) three years beyond any termination of the Dentist-patient relationship. As a matter of office policy, Dentist is requiring all patients in its practice sign the Mutual Agreement to Maintain Privacy so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Dentist's patients.

Patient and Dentist acknowledge that breach of this agreement may result in serious, irreparable harm. In addition to compensation for consequential damages, Patient and Dentist agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

Patient Signature_____ Date_____

Patient Name (printed) _____ _____

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ROBERTSDALE DENTAL CARE

VITAL INFORMATION ABOUT YOUR DENTAL INSURANCE

Our office is happy to help you file your insurance to receive the dental benefits that you and your employer are paying premiums for. Dental benefit plans can vary from company to company with different procedures covered or not covered. Insurance companies base the amounts that they will pay toward your dental treatments on restricted fee schedules related to premium payments and geographical location. In other words, your insurance plan will pay only what it allows for each service, regardless of what the actual fee might be. Deductibles and co-payments are typically built into most plans and their required payment is strictly regulated by state law. Both our office and you as the policy beneficiary can be prosecuted if deductibles and co-payments are not collected. Your Employee Benefits Director can usually help you become familiar with your plan and its restrictions, and our office will assist you in maximizing your benefits.

Our responsibilities:

1. Complete your insurance claim forms and submit them to your carrier for you within 24 hours of treatment.
2. Use current American Dental Association coding for correct reporting of procedures.
3. Accept direct payment from your carrier and keep track of balances.
4. If necessary, re-file your insurance a second time within a 60 day period.

Your responsibilities:

1. Pay fees not covered by your plan at the time of treatment.
2. Provide our office with necessary information concerning your insurance coverage to allow correct filing of claims.
3. Understand that your plan is a contract between you and your employer and the insurance carrier. Our office will do all we can to facilitate claims payment, but we do not have the power to make your plan pay.
4. Pay any account balance not paid by insurance after 2 billing attempts.

We thank you for choosing our office and will do all we can to help you obtain the benefits you deserve. Please sign this form below. We will keep one copy on your chart and will give you one copy for your records if requested.

I hereby authorize payment directly to the dental office of the insurance benefits otherwise payable to me. I understand that I am ultimately responsible for all costs of dental treatment. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers.

_____

Patient or Insured Date