WESTCLIFF FAMILY DENTISTRY

OFFICE POLICY AND CONSENT FORM

Please remember that we are here to serve you in a comfortable and professional atmosphere. Our goal is to provide you with the very best quality of dental care.

INSURANCE AND PAYMENT POLICIES

- **FEES FOR SERVICE AT OUR OFFICE WILL BE REQUESTED AT THE TIME OF YOUR VISIT.** For treatment involving fees above $500.00, special financial arrangements may be discussed with our financial coordinator or office administrator.
- For patients with Dental Insurance: Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. We will file your claim for you at no charge; however, we ask that your deductibles and your estimated portions (20%-60%) be paid as services are rendered. Although we gladly file dental insurance claims as a courtesy to you, any and all account balances are ultimately your responsibility.
  Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
  All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatment.
- Please note, for your convenience, we do accept VISA, MasterCard, Discover and Care Credit as well as checks and cash.

OFFICE POLICIES

- Your appointment time is set aside especially for you. We ask for the courtesy to the Doctor and to other patients that you keep your scheduled appointments. **If you must change or miss an appointment, we require a 48-hour notice. Cancellations, last minute rescheduling or failure to show will result in a broken appointment charge of $80.00, or no reappointment. If more than one family member is scheduled & fails to make their appointment a $80 cancellation fee will be assessed for the first individual and $50 for each family member thereafter. This policy is strictly enforced due to our high volume of patients.**
- Our office will provide confirmation calls and postcards to you. We ask that if we are unable to reach you, that you please contact us as soon as possible to confirm your appointment. Failure to do so may result in your appointment needing to be rescheduled.
- We realize that many families are in a state of change. The policy in our office is that the parent who requests treatment for a child is responsible to us for all fees incurred.
- We will be fair in working out special finances with you, but please also be fair to us with your commitments. A 1.5% finance charge will be assessed monthly on all overdue balances.
- Treatment appointments made that **exceed $500.00 will require 10% down** to hold the appointed time.

CONSENT

I have read and understand all the above information. The undersigned hereby authorizes the Doctor to perform those diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Date _____ Signature_____(Patient, Parent or Guardian)

Patient Information

Please Print

Circle One: Dr/Mr/Mrs/Ms/Miss

First: _____ Middle: _____ Last: _____Jr/Sr: _____

Street: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Work Phone: _____

Email Address: _____ May we contact you by email? (circle) **Yes No**

Patient Social Security Number: _____ Patient Date of Birth: _____ Sex: (circle) **M F**

Emergency Contact: _____ Phone: _____

Preferred Pharmacy_____

How did you hear about us? ☐ Flyer ☐ Social Media ☐ Referral ☐ Other: _____

Insurance Information

Do you have Dental Insurance? (circle) Yes No Do you have Secondary Dental Insurance? (circle) Yes No

Primary Insured		Secondary Insured	
Subscriber Name		Subscriber Name	
Subscriber SSN		Subscriber SSN	
Date of Birth		Date of Birth	
Relationship to Subscriber	☐ Self ☐ Spouse ☐ Child ☐ Other	Relationship to Subscriber	☐ Self ☐ Spouse ☐ Child ☐ Other
Employer Name		Employer Name	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
Insurance ID #		Insurance ID #	
Insurance Phone #		Insurance Phone #	

Authorization for Release of Health Records to External Parties

I authorize the disclosure of information from my treatment records to:

Name of Recipient: _____

Relationship to the Patient: _____

I give authorization to disclose the following information:

- ☐ All treatment information
- ☐ Information specifically related to these treatment dates

Starting Date: _____ End Date: _____

I understand that I may withdraw or revoke my permission at any time. I may revoke this authorization by notifying Westcliff Family Dentistry in writing.

Signature of Patient (or Patient Representative) _____ Date: _____

Printed Name of Patient (or Patient Representative) _____

Health Information

We take your oral health very seriously. But before we start your treatment, we need some brief information on your medical history which may affect your treatment. All information is confidential.

Patient's Name: _____ Date of Birth: _____
Physician's Name & Phone #: _____
Reason for today's visit? _____
How would you rate your teeth on a scale of 1 to 10? _____
Have you ever been treated for periodontal (gum) disease? (circle) Yes No
Ever had Novocaine or other local anesthetic? (circle) Yes No
Are you interested in tooth whitening? (circle) Yes No
If wearing dentures, age of dentures: _____Are you interested in new dentures? (circle) Yes No
Are you taking or have taken Oral Bisphosphonates? (e.g., FOSAMAX, ACTONEL, BONIVA, or IV Bisphosphonates, (e.g., ZOMETA, AREDIA) (circle) Yes No Taken for how long? _____
Have you taken antibiotics prior to dental procedures in the past? (circle) Yes No
Have you ever had an adverse reaction or become ill after taking penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? (circle) Yes No

List any medications you are allergic to:
1. _____ 2. _____ 3. _____ 4. _____
List any medications you are taking including non-prescription drugs and herbals/vitamins:
1. _____ 2. _____ 3. _____ 4. _____

Women patients only:

Is there a possibility of pregnancy? Yes No
Estimated delivery date: _____/____/____
Are you nursing? Yes No
Are you taking any birth control prescriptions? Yes No

Do you have a history of:	Y	N		Y	N		Y	N		Y	N
Rheumatic Fever			Asthma			Use of Tobacco Products			Alcoholism		
Heart Murmur			Allergies or Hives			Thyroid Disease			Psychiatric Treatment		
Mitral Valve Prolapse			Anemia			Epilepsy or Seizures			Mouth sores/growths		
Diabetes			Teeth Grinding/Clenching			Fainting or Dizzy Spells			Aspirin/Anticoagulant Therapy		
Venereal Disease			Arthritis			Pace Maker/Heart Surgery			Ulcers or Stomach Problems		
High Blood Pressure			HIV Positive/AIDS			Pain in your jaw (TMJ)			Any type of Implant		
Low Blood Pressure			Blood Transfusion			Latex Allergy			Cancer (Type:)		
Any type of Transplant			Heart Problem ( )			Sinus Problems			Any Artificial Hip, Knee or other Joint		
Drug Addiction			Dialysis			Excessive Bleeding			Other Disease or Illness:		
Hepatitis (Type:)			Chemotherapy			Stroke					
Liver Disease			Radiation Treatment			Kidney Disease					

Patient's Signature_____ Date_____

This notice describes how medical/ Dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your Dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at 682-708-3095 .

Information We Collect About You

We collect personal information about you and your family as part of our new patient process, during your care, and from other health care entities you utilize such as, other Dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During the course of your treatment we will collect Dental information regarding diagnosis, treatment plans, progress and any test results or films.

How Your Information Is Used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other Dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. *Westcliff Family Dentistry* does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest, we may be required to disclose certain information to local, state or national health organizations or government agencies.

We may contact you to provide appointment reminders or information about treatment.

Safeguarding Your Personal and Health Information

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

Westcliff Family Dentistry maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated, you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with *Westcliff Family Dentistry*.

Changes to Our Privacy Policy

All new patients will review a copy of our privacy policy. *Westcliff Family Dentistry* occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

Your Right to Restrict Use of Information

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Patient Acknowledgement: I have reviewed Westcliff Family Dentistry Privacy Policy.

Patient's Name (please print): _____ Date: _____

Patient Signature: _____ Date: _____