Welcome To
Grace Dental

PATIENT INFORMATION

In order to better serve you, we need you to complete the following information. **Please print.**

Demographic Information

Date: _____/_____/_____ Patient Name: _____

Please Provide Middle Name or Middle Initial

SSN: _____ ☐ Male ☐ Female Birthdate: _____ Home Phone: _____

Home address: _____ City: _____ State: _____ Zip: _____

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or parent's employer: _____ Work phone: _____

E-mail address: _____ Cellular phone: _____

Spouse or parent's name: _____Phone: _____

Person to contact in case of emergency: _____ Phone: _____

Responsible Party

Name of person responsible for account: _____ Relationship to patient: _____

Address: _____ Home phone: _____ Birthdate: _____

SSN #: _____ Employer: _____ Work phone: _____

E-mail address: _____ Cellular phone: _____

Insurance Information

Name of Insured: _____ Relationship to Patient: _____

Birthdate: _____ SSN: _____ Date employed: _____

Their Employer: _____

Primary Insurance Name: _____ Policy #: _____ Group #: _____

Ins. Co. address: _____ City: _____ State: _____ Zip: _____

Insurance Phone # _____ Policyholder ID # _____

SECONDARY INSURANCE

Do you have any additional insurance? ☐ Yes ☐ No If, yes, please complete the following:

Name of Insured: _____ Relationship to Patient: _____

Birthdate: _____ SSN: _____ Date employed: _____

Secondary Insurance Name: _____ Policy #: _____ Group #: _____

Ins. Co. address: _____ City: _____ State: _____ Zip: _____

Insurance Phone # _____ Policyholder ID # _____

Financial Policy

Insurance

Grace Dental, P.A. ("Grace" or 'We") must receive accurate insurance information at the time of the appointment. If not, patients or the financially responsible party for the patient ("You" or "Your") are required to pay in full for fees before services are rendered. You will also be responsible to pay fees in full before services are rendered if Your insurance provider refuses to grant assignment of benefits to Grace, Grace anticipates no payment from your insurance provider or You elect not to have procedures submitted to your insurance provider. In the case of the latter, see administrative personnel before services are rendered regarding required processes you must follow to have Grace withhold dental procedure information from your insurance carrier. You are responsible for paying deductibles and co-payments before the time of service. Actual amounts received from insurance plans may vary greatly from any estimate of benefits we may provide You. Regardless, You are responsible for paying all charges not covered by Your primary insurance plan. If the accuracy of any such estimate will impact Your decision as to the acceptance of a treatment proposal, You are encouraged to contact Your dental insurance carrier for any clarification from them before beginning treatment. We will submit a primary insurance claim for You up to two times per appointment. Any further insurance appeal becomes Your responsibility. You are responsible for payment in full the sooner of: (A) when insurance makes payment on Your claim; and (B) 60 days from the date services are provided even if the insurance company has not paid.

Payment Terms and Other Issues

Full payment of fees is due before the time of service is rendered unless insurance filings are involved as described above. Payments can be made by cash, check or various charge cards accepted by Grace. Any and all persons responsible for payment will receive a statement for Your services. Should You wish to limit those parties that may receive a statement for services provided to You (e.g., insurers, policy holders), *prior to the service*, You must indicate and accept full financial responsibility for payment of the service, make payment for such service and indicate Your restriction(s) to Grace. We are not responsible for any amounts You may owe other health professionals.

Finance charges on account balances due to Grace accrue at a rate of 1.5% per month and are compounded each month that an account balance due Grace remains. However, when insurance is filed, finance charges may be waived for the period that is the lesser of: (A) the time outstanding to file and receive insurance proceeds; and (B) 60 days from the date services are rendered. This monthly finance charge rate is subject to change without notice, but will not exceed rates allowed under applicable law.

A service charge for returned checks will be assessed. Currently this fee is $30 and may change from time to time without notice. You may also be responsible, up to limitations set by law, for fees charged by collection agencies or attorneys in situations where they are involved in the collection of account balances.

Authorization and Agreement

I authorize release of any information concerning the Patient's health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to Grace Dental, P.A. or doctor.

I certify that I have read, understand, and agree to all terms of the Financial Policy above. I further understand that a photo static copy of this document shall be considered as effective and valid as an original. I will hold Grace Dental, P.A. and /or any of its employees harmless for any omissions I have made in completion of information.

I agree to pay in full all outstanding balances at the time work and/or services are completed. I recognize that my failure to pay my account in full within thirty days after work and/or services are completed may result in my balance being placed with a collection agency and possible listing with the credit bureau(s).

I further agree, in order for you to service my account or to collect any amounts I may owe, your organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of your debt collection agency, may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Your organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of your debt collection agency may also contact me by sending text messages or emails, using any e-mail address I provide to you. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I have read this disclosure and agree that the Lender/Creditor, its ancillary providers, HIPAA business associates, vendors, and its debt collection agents may contact me as described above.

_____ _____

Printed Name of Patient Patient **Signature**

_____ _____ _____

Responsible Party **Signature** **Printed** Name of Responsible Party Date

GRACE DENTAL, P.A.
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND AUTHORIZATION & RELEASE FORM

Date:_________________________

Patient Name:____

Patient Address: ____ Email Address: _______________________________

Home Phone: ________________________ Work Phone: _____________________ Cell Phone: ______________________________

Personal Representative Name:____

Relationship of Personal Representative: ____

Contact in Case of Emergency ____________________________ Phone: _______________________ Relationship: ______________

PLEASE LIST ANY OTHER PERSONS WHO CAN ACCESS TO / RECEIVE YOUR HEALTH INFORMATION:

Others:

Name:____ Phone _______________________Relationship: ___________________

Name:____Phone______________________Relationship:___________________

* By providing the names above, you authorize Grace Dental, P.A. to disclose your health information to these persons. Grace Dental, P.A. may contact the above individuals until authorization to do so is revoked.

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PLEASE CHECK THE BOX(ES) BELOW TO AUTHORIZE THE FOLLOWING:

❖ **CONTACT FROM THIS OFFICE TO CONFIRM APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:**

- ❑ All of the Following
- ❑ Home Phone Confirmation
- ❑ Work Phone Confirmation
- ❑ Text Message to my Cell Phone
- ❑ Email Confirmation
- ❑ Cell Phone Confirmation

❖ **INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:**

- ❑ All of the Following
- ❑ Home Phone Confirmation
- ❑ Work Phone Confirmation
- ❑ Text Message to my Cell Phone
- ❑ Email Confirmation
- ❑ Cell Phone Confirmation

* Grace Dental, P.A. will use the contact information provided on this Form. It is the responsibility of the patient / personal representative to update the contact information above (i.e., new telephone number / email address).

By signing below, the undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Grace Dental, P.A. A copy of this signed, dated document shall be effective as the original.

Patient Signature >>>>X____ **Date:**________________

Personal Representative Signature >>>>X____ **Date:**________________

<u>Office Use Only</u>
As Privacy Officer, I attempted to obtain signature on this form but did not because:

____

____
Signature of Privacy Officer Date

Name (Printed)_____ **DOB: _____/_____/_____**

Please circle any of the following that you are now or have been treated for in the past.

Anemia	Emphysema	Kidney Disease
Arthritis	Epilepsy	Liver Disease
Artificial Heart Valve	Excessive Bleeding	Mitral Valve Prolapse
Artificial Joints	Glaucoma	Pacemaker
Asthma	HIV Positive	Parkinson's Disease
Autism	Hay Fever	Radiation Treatment
Blood Disease	Head Injuries	Respiratory Problems
Blood Transfusion	Heart Disease	Sinus Problems
Bruise Easily	Heart Attack	Stomach Problems
Cancer	Heart Murmur	Stroke
Cerebral Palsy	Heart Surgery	Thyroid Problem
Chest Pain (Angina)	Hemophilia	Tuberculosis
Depression	Hepatitis	***OTHER (Please list):***
Diabetes	High Blood Pressure	_____
Dizziness	Immune System Disorders	_____
Down Syndrome	Jaundice	_____

Are you currently pregnant or suspect you may be pregnant now? Yes ○ No ○
Please provide any additional information that would be helpful to know about any items circled above

_____

_____

Please circle or note any allergies or sensitivities you have

Aspirin Barbiturates Codeine Latex Peanuts Penicillin Sulfa

Other:_____

	YES	NO
Are you currently under medical care at this time?	○	○
Have you been hospitalized in the last 5 years?	○	○
Do you use any form of tobacco? (Please list type below)	○	○
Do you wear a mouth guard while participating in sporting events?	○	○

Please list all medications you are currently taking:

_____

_____

Physician #1 Name: _____ Phone: _____
Physician #2 Name: _____ Phone: _____

Signature of Patient or Legal Guardian _____TODAY'S DATE:____/_____/_____