Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date:_____E-Mail: _____

Phone (Cell): _____ (Home): _____ (Work): _____ Ext: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: _____
a

_____
City State Zip Code

Referred by: ☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐Another patient, friend

☐Another patient, relative ☐ Other_____

Name of person or office referring you to our practice:_____

Health Information

To receive treatment in this office you must answer all questions on this history form. The questions asked relate directly to the safe and effective treatment you are to receive in our office – to the best of your ability, honest answers must be given. *(All information on this form and any subsequent interview will be held in the strictest confidence and will not be disclosed without your express and written permission.)*

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ HIV ☐ HIV Positive
☐ Abnormal Blood Pressure (high)
☐ Anemia
☐ Excessive Bleeding
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Chemo
☐ Radiation
☐ Diabetes
Type _____

☐ Dizziness
☐ Epilepsy
☐ Fainting
☐ Glaucoma
☐ Head Injuries
☐ Heart Trouble
☐ Heart Attack
☐ Angina
☐ Heart Murmur
☐ Congenital Heart Disease
☐ Hepatitis (please circle)
Type: A B C
☐ Kidney Disease
☐ Liver Disease

☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date: _____
☐ Respiratory Problems
☐ Rheumatic Heart Disease
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Blood Thinners
☐ Convulsions
☐ Tuberculosis

☐ Tumors
☐ Growths
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
Smoke Y N
Alcohol Y N
☐ Other
_____

If you checked any of the above, please explain:

_____
_____

Please list all medications you are currently taking:

_____
_____

- Have you been admitted to a hospital or have had a serious illness during the past five years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Physician: _____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

Health Information (continued)

Date of Last Dental Visit: _____ **Reason for this visit:**_____

In respect to any previous dental treatment, have you:

1. Ever fainted? _____
2. Had an allergic reaction? _____
3. Had abnormal bleeding? _____
4. Any other complications during dental treatment? If yes, describe _____
5. Do your gums bleed on brushing or eating? _____
6. Does food catch between your teeth? _____
7. Have you noticed any gum swelling around your teeth? _____
8. Do you ever avoid any part of the mouth while brushing/chewing? _____
9. Are you dissatisfied with your teeth and their appearance? _____
10. Are you deeply concerned about the finances required to return your mouth to excellent dental health? _____
11. Do you want to learn to control dental disease and retain your teeth? _____
12. Do you have an unpleasant taste or odor in your mouth? _____
13. Have you ever had any teeth removed? _____
14. How long have these teeth been missing? _____
15. Do you feel you will eventually wear artificial dentures? _____
16. Have your teeth shifted, are their spaces between your teeth now where there was none, or are some of your teeth becoming loose? _____
17. Are any of your teeth sensitive to heat, cold, or pressure? _____
18. Do you grind your teeth or clench your jaw? _____
19. Do you have any pain or clicking in the jaw joint around your ear? _____
20. Have your jaw muscles ever been sore? If yes, describe: _____
21. Are there any sores or growths in your mouth? _____
22. Do any of your teeth ache? _____
23. Do you have any other dental complaint? _____
24. Why did you leave your last dentist? _____
25. What is your present dental problem? _____
26. What do you expect out of your teeth in the next 5-6 years? _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Gregory A. Nairn, D.M.D.
131 S. College Street
Washington, PA 15301
Phone: 724-228-3142
Fax: 724-228-9771

Rooted in Community
Our Family Caring for Yours

Associates in Dentistry Office Policies

- We require at least 48 hours advance notice for appointment cancellations.
- If your notice of office cancellation is not received within the specified time, and the appointment is not kept, this will constitute in a broken appointment. We reserve the right to charge a $50.00 fee for hygiene and a $75.00 fee for the doctor before another appointment can be scheduled.
- We reserve the right to reschedule an appointment for patients arriving more than (15) fifteen minutes late. Further, for patients arriving late, due to time constraints, we reserve the right to perform only those procedures that will fit the doctor's schedule.
- We reserve the right to terminate dental treatment/services for any patient that has more than three broken appointments.
- There will be a $30.00 fee for all returned checks.
- All dental procedures not covered by your insurance (private insurance or all state Medicaid plans) will have to be paid by the responsible party. Please review your dental benefits booklet carefully as each insurance company has different coverage schedules.
- Unmet dental insurance deductibles and all uncovered procedures must be paid the day the services are rendered.
- Any patient that does not have dental insurance (cash paying patient) must pay balances in full the day the services are rendered.
- Insurance co-payments and deductibles are to be paid prior to procedure completion and before scheduling the next appointment.
- If services are performed and lab work completed and treatment is terminated by the patient for any reason prior to completion, the patient is responsible for the time, materials, and lab costs associated with the completed appointments and will not be refunded any payments made.

Authorization and Release

My signature below acknowledges that I understand the office policies at Associates in Dentistry. I further understand that my child's (minor) dental treatment is conditioned on the above policies. It is further understood that "we" refers to Associates in Dentistry.

Signature of Patient: _____ Date: _____

Patient Name (Printed): _____

Associates in Dentistry
Rooted in Community
Our Family Caring for Yours

Gregory A. Nairn, D.M.D.
131 S. College Street
Washington, PA 15301
Phone: 724-228-3142
Fax: 724-228-9771

ASSIGNMENT OF BENEFITS AGREEMENT

Associates in Dentistry will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.

- We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.

- We will do our best, based on the information you provide us, to predict what your level of coverage for a particular procedure will be. However, it is up to the patient to verify specific dental benefits or coverage. The patient is responsible for payment of the difference. We require you to pay the co-payment, which is the amount not covered by your insurance company, at the time we provide service to you.

- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time.

- Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.

- Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE DOCTOR.

_____
Print Name

_____ _____
Signature of Patient/Responsible Party Date

Gregory A. Nairn, D.M.D.
131 S. College Street
Washington, PA 15301
Phone: 724-228-3142
Fax: 724-228-9771

Associates in Dentistry Dental Insurance Review

Dear Valued Patient,

Associates in Dentistry has prepared this memorandum to help you better understand the complexities of dental insurance. We realize how confusing it can be.

- We would like to highlight a misconception – dental insurance is not designed to pay for all dental care. It is basically a supplement to medical insurance, much like vision coverage. Most dental insurances have limits and/or various degrees of co-payments and deductibles.

- The payments made to Associates in Dentistry by dental insurance companies are based on usual, customary, and reasonable (UCR) fees. This means that the insurance companies determine a list of covered dental services with an assigned dollar amount. That dollar amount represents just how much the plan will pay for those services that are covered. Every insurance company has different UCR tables and most have several different tables depending on the procedure. This can also include annual deductibles and maximums, exclusions, and limitations.

- Most often, the UCR table does not represent the dentist's full charge for those services. If it is noted that the fee that your dentist has charged you is higher than the reimbursement levels of UCR, this does NOT mean your dentist is overcharging you. Although these limits are called "customary," they may or may not accurately reflect the fees that dentists in Southwestern PA charge. There is a wide fluctuation and lack of government regulation on how a plan determines the "customary" fee level.

- Our fees are based on a combination of our costs, our time, and our constant dedication to providing our patients with the highest quality dental care.

- The treatment recommended by our office is never based on what your insurance company will pay, but on what is needed to maintain healthy oral hygiene.

- It should be understood that the dental insurance contract is between the insurance company and the patient, who bears the ultimate financial responsibility.

- We will do our best, based on the information you provide us, to predict what your level of coverage for a particular procedure will be. However, it is up to the patient to verify specific dental benefits or coverage. The patient is responsible for payment of the difference.

Signature of Patient: _____ Date: _____

Patient Name (Printed): _____

Gregory A. Nairn, D.M.D.
131 S. College Street
Washington, PA 15301
Phone: 724-228-3142
Fax: 724-228-9771

ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

****YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT****

I, _____, HAVE RECEIVED OR READ A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

_____
PRINT NAME

_____
SIGNATURE

_____
DATE

FOR OFFICE USE ONLY

WE ATTEMPTED TO OBTAIN WRITTEN ACKNOLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES; HOWEVER 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