ELGIN FAMILY DENTAL

306 North Hwy 95
Elgin, Texas 78621

New Patient Form

Please fill out all the information to the best of your knowledge. All answers will be kept confidential. If you have any questions, please ask us, and we'll be happy to assist you.

Date:

Patient Information

Title: First Name: Middle Name: Last Name: I prefer to be called:

Gender: DOB (MM/DD/YYYY): Marital Status: Social Security #: Driver's License State & #:

Street Address:

City: State: Zip:

Mailing Address (if different than above):

City: State: Zip:

Home Phone: Work Phone: Cell Phone: Email Address:

For appt confirmations, please select your preference(s):

Text message
Voice Message
Email message

Cell #
Home #
Work #

Employment: Employer's Name: Employer's Phone #:

Employer's Address: City: State: Zip:

Responsible Party Information

If patient is a minor, name of person responsible for this account:

Last First Middle DOB (mm/dd/yyyy)

Address:

City: State: Zip: Email:

Home# Work# Cell# Driver License

Emergency Contact Information

Last Name First Middle Relationship Phone #

Dental Insurance Information

Do you have Primary Dental Insurance? Yes No

Group ID

Insurance Co. Name

Insurance Co. Phone

Employer Name:

Subscriber (Last, First Name)

Subscriber address

City, St, Zip

Relationship to Patient

Subscriber ID

Do you have Secondary Dental Insurance? Yes No

Group ID

Insurance Co. Name

Insurance Co. Phone

Employer Name:

Subscriber (Last, First Name)

Subscriber address

City, St, Zip

Relationship to Patient

Subscriber ID

Medical Information

Known Allergies	Y	N	Blood Transfusion	Y	N	Liver Disease	Y	N
If YES, please mark the following:			Bone Disease	Y	N	Mitral Valve Prolapse	Y	N
Acrylic	Y	N	Cancer	Y	N	Nervous/Anxious	Y	N
Adhesive	Y	N	Chemotherapy	Y	N	Neurological Disorders	Y	N
Aspirin	Y	N	Cholesterol (High)	Y	N	Pregnant	Y	N
Codeine/Other Narcotics	Y	N	Circulatory Problems	Y	N	Psychiatric Care	Y	N
Erythromycin	Y	N	Diabetes	Y	N	Radiation Treatment	Y	N
Latex Rubber	Y	N	Dizziness/Fainting	Y	N	Respiratory Problems	Y	N
Local Anesthetics	Y	N	Drug Addiction	Y	N	Rheumatic Fever	Y	N
Morphine	Y	N	Ear/Hearing Problems	Y	N	Rheumatism	Y	N
Epinephrine	Y	N	Emphysema	Y	N	Sinus Problems	Y	N
Penicillin	Y	N	Epilepsy/Seizures	Y	N	Skin Disease	Y	N
Sulfa Drugs	Y	N	Excessive bleeding	Y	N	STD/Venereal Disease	Y	N
Tetracycline	Y	N	Eye/Vision Problems	Y	N	Stomach/Intestinal	Y	N
Other:____________	Y	N	Genital Herpes	Y	N	Stroke	Y	N
Medical History:			Glaucoma	Y	N	Thyroid Conditions	Y	N
AIDS/HIV Infection	Y	N	Head Injuries	Y	N	Tobacco Dip/Chew	Y	N
Alzheimer's Disease	Y	N	Heart Disease	Y	N	Tobacco Smoker	Y	N
Anemia	Y	N	Heart Murmur	Y	N	Tuberculosis	Y	N
Angina	Y	N	Heart Pacemaker	Y	N	Tumor or Growths	Y	N
Anorexia/Bulimia	Y	N	Heart Stint	Y	N	Ulcers	Y	N
Arthritis/Gout	Y	N	Hemophilia	Y	N	Have you taken Actonel	Y	N
Artificial Heart Valve	Y	N	Hepatitis B or C	Y	N	Have you taken Aredia	Y	N
Artificial Joints/pins	Y	N	High Blood Pressure	Y	N	Have you taken Boniva	Y	N
Asthma/Hay Fever	Y	N	HPV	Y	N	Have you taken Fosamax	Y	N
Blood Disorders	Y	N	Jaundice	Y	N	Have you taken Zometa	Y	N
Blood Thinners	Y	N	Kidney Disease	Y	N	Have you taken diet drug Fen_Phen	Y	N

Are you now under the care of a physician? Y N

If Yes, please explain:

Name of Physician : Phone #:

Have you had any serious illness, operation or been hospitalized within the past 5 years? Y N

If Yes, please explain:

Have you ever had gum disease or surgery Y N

If Yes, when

List of all Medications that you are presently taking: (If you have a printed list, we can copy it at your visit):

Financial Policy

Thank you for choosing Elgin Family Dental for your dental needs. We are committed to providing state-of-the-art, comfortable and personalized dental care for you and your family. Please read the following financial policy and sign in the space provided. Please ask any questions you may have concerning this policy. We will furnish you a copy at your request.

Photo ID and Insurance Card (if applicable) will need to be copied by office staff.

- **New Patient Emergency Appointment Payments**: In order for patients to establish credit in our office, we request payment at the time of service for new patient emergency procedures. For your convenience we accept cash, personal checks, money orders and credit cards (Visa, Master Card, American Express and Discover).
- **Non-Insurance Patients**: Patients without insurance are expected to pay for all services rendered. For your convenience we accept cash, personal checks, money orders, and credit card payments at the time of service. Interest free dental loans or an extended payment plan are available through CareCredit. We will help you fill out the necessary applications. For information on these services, please ask our office staff. For crowns, bridges, partials and dentures: a laboratory retainer fee of half of the charged fee is due on the day impressions are taken unless prior payment arrangements have been approved.
- **Insurance:** When your appointment is made, we will ask for your insurance information, so we may verify this with your insurance company. You will also need to bring your insurance card to your appointment. We do ask that you read your policy thoroughly so that you are fully aware of the benefits provided and the limitations imposed. Most insurance are accepted at Elgin Family Dental. Please contact your insurance company with any questions regarding your coverage. Your insurance policy is a contract between you, your employer, and your insurance company. We are not a party to that contract; however, as a courtesy to our patients, we will file and accept assignment of insurance benefits. Once we confirm your dental coverage, you will be asked to pay your deductible and patient portion at the time of service. Not all services are a covered benefit in all contracts. Some employers and insurance companies arbitrarily select certain services they will not cover. You are responsible for the cost of your treatment and any insurance reimbursement problems. It is unusual for all of the charges to be paid by insurance but our business office staff will strive to help you obtain your maximum benefits by prompt and efficient processing of your claims. Anticipation of benefits expected are clearly estimates. The actual balance due after the insurance payment is the responsibility of those seeking treatment. We do have several methods of payment designed to help you and your family get the quality of care you deserve. Please feel free to ask our office staff about options for payment. Assignment of Insurance Benefits: I hereby authorize payment directly to Elgin Family Dental for the dental service benefits otherwise payable to me. (**INITIAL**)
I understand that if performed dental services are not under contract with my insurance carrier or I have met my contract limitations, I am responsible for this fee. (**INITIAL)**
- **Children:** The parent or guardian who brings the child into the office for dental treatment is financially responsible regardless of dental insurance or legal responsibilities another parent or guardian may have toward this child. **(Initial)**
- **Wireless Telephone Calls:** If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls (including autodialed calls and prerecorded messages) from the clinic, its successors and assigns, and the affiliates, agents and independent contractors, including servicers and collection agents, of each of them regarding services rendered, or my related financial obligations. **(INITIAL)**
- **Cancellations of Appointments/No show (did not call to cancel appointment):** When you do not show for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. It's very important that you call within 24 hours in advance to cancel your appointment. After 3 "no-shows", we will require you to pay a deposit for the appointment in advance before we can schedule you another appointment. We reserve the right to deny any future scheduling of appointments due to repeatedly missed or canceled appointments. (**INITIAL)**
- **Past Due Accounts/Returned Checks:** A billing charge of one percent (1%) per month will be charged to your account after 90 days. Outstanding balances after 90 days will be transferred to a collection agency unless prior arrangements have been made with our front office. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys' fees , we incur in such collection efforts. Patients, who have allowed their account to be turned over to collections, will be expected to satisfy their financial obligation to Elgin Family Dental and to pay future services in advance, before being seen by the dentist. There will be a $30.00 fee for each returned check. In addition, you will be asked to bring cash to Elgin Family Dental to cover the returned check and the returned check fee. **(INITIAL)**

HIPAA Patient Acknowledgement

To comply with one of HIPAA's requirements we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

From time to time it may be necessary for us to make disclosures of your information in connection with our treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Please sign this form below to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment and to acknowledge that you have today either received or reviewed a copy of our notice of privacy practices.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above. I also acknowledge that I have today received or read a copy of the Elgin Family Dental Notice of Privacy Practices.

I am also signing for my minor children:

I also give consent for my treatment to be discussed with the following individuals: (e.g. spouse, parent, adult child, care giver) ____

____

____

____

I also give my permission for information regarding___ appointments, ___insurance benefits, ___financial arrangements to be discussed with the above individuals, except: ______________________________

____

- I have read and completed the information contained in the ***New Patient Registration form*** and understand that the information contained in these pages is necessary to provide me with dental care in a safe and efficient manner. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect info can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status**. (Initial)**
- I have read the office ***Financial Policy***. I authorize my insurance company to pay Elgin Family Dental all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize Elgin Family Dental to release all information necessary to secure the payment of benefits. I understand that I am Fully Financially Responsible for all charges whether covered or not covered or denied by my Insurance Company**. (Initial)**
- I authorize the team to perform any necessary dental services that either I or my child may need and have consented to during diagnosis and treatment discussions**. (Initial)**
- I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this notice**. (Initial)**

Print Responsible Party Name: **Date:**

Signature of Responsible Party (Use mouse, stylus or finger to sign):