# Monrovia Family Dentistry

# New Patient Packet

***Instructions: Please fill out the form in its entirety and bring it with you on the day of your appointment. Note that you will be able to fill in most fields and then print it out; however, you will need to go back once you have printed the document and fill in some of your medical history by hand.***

**MEDICAL HISTORY FORM**

Date _____

Name _____ (Last / First / Middle) Preferred Name _____

Address _____ (Number / Street) SS# _____

City _____ State _____ Zip Code _____

Home Phone ( ) _____ Email _____

Cell Phone ( ) _____ Preferred Contact Number: ☐ Work ☐ Home ☐ Cell

Employer _____ Work Phone ( ) _____

Date of Birth ____/____/____ (mo. / day / yr.) Sex ☐ M ☐ F Height _____ Weight _____ Single _____ Married _____

Name of Spouse or Parent _____ Their Employer _____

Their SS# _____ Their DOB _____ Their Work Phone _____

Who to contact in case of emergency? _____ Phone ( ) _____

Referred by _____

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For the following, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your visit you will be asked some questions about your responses to this questionnaire and additional questions concerning your health.

1. Are you in good health? ..... Yes No
2. Has there been any change in your general health within the last year? ..... Yes No
3. My last physical examination was on _____
4. Are you now under the care of a physician? ..... Yes No
   If so, what is the condition being treated? _____
5. The name and phone # of my physician(s) _____
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? ..... Yes No
7. Are you taking any medicine(s) including non-prescription medicine? ..... Yes No
   If so what medicine(s) are you taking? _____
   _____
8. Has a physician ever told you to take an antibiotic before dental treatment? ..... Yes No
   If so, for what condition? _____

Of the following diseases or problems, please circle ALL that apply:

Damaged heart valves
Artificial heart valves
Heart murmur
Rheumatic heart disease
Heart attack, date(s) _____
Angina (chest pain)
Coronary insufficiency
Coronary occlusion
High blood pressure
Arteriosclerosis
Stroke
Shortness of breath
Inborn heart defects
Cardiac pacemaker
Other heart problems

Sinus trouble
Asthma
Emphysema
Other respiratory problem
Epliepsy
Other neurological problem
Diabetes
Hepatitis
Liver disease
AIDS or HIV infection
Thyroid problem
Arthritis
Stomach ulcer
Acid reflux
Kidney problems

Tuberculosis, date _____
Persistent cough
Swollen glands in neck
Low blood pressure
Sexually transmitted disease
Mental health problem
Abnormal bleeding
Blood transfusion
Anemia
Other blood disorder
Treatment for tumor / growth
Joint replacement, date(s) _____
Other _____
_____
_____

12. Are you allergic or have you had a reaction to:
    a. Local anesthetics ..... Yes No
    b. Penicillin ..... Yes No
    c. Other antibiotics: please list ..... Yes No

    _____

    _____

    d. Sulfa drugs ..... Yes No
    e. Barbiturates, sedatives, or sleeping pills ..... Yes No
    f. Codeine or other narcotics ..... Yes No
    g. Latex ..... Yes No
    h. Other ..... Yes No
13. Have you had any serious trouble associated with any previous dental treatment? ..... Yes No
    If so, explain _____

    _____
14. Do you have any disease, condition, or problem not listed above that you think I should know about? ..... Yes No
    If so, explain _____

    _____
15. Do you have dental implants? ..... Yes No
16. Are you wearing removable dental appliances? ..... Yes No

**Women**

17. Are you pregnant or trying to get pregnant? ..... Yes No
18. Are you nursing? ..... Yes No
19. Are you taking oral birth control pills? ..... Yes No

Chief Dental Complaint _____

_____

Due to safety concerns, only the patient being treated is allowed in the treatment room. Please discuss special considerations (for example, one parent accompanying a child) with a staff member prior to scheduling an appointment.

Minor patients (those below the age of 19) must have a parent or guardian present in our facility during all treatment appointments.

If you need to cancel your appointment, we must receive notice at least 24 hours in advance. This allows us the opportunity to schedule another patient. It is our policy to dismiss patients after 3 broken appointments without 24 hours notice.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

I hereby consent to dental treatment by the Monrovia Family Dentistry team. I understand that my treatment options depend on my current oral health conditions. I will thoroughly discuss and understand the risks, benefits and alternatives for my dental treatment before I allow the dental team to begin treatment.

_____

Signature of Patient or Guardian

**MONROVIA FAMILY DENTISTRY**
**INSURANCE INFORMATION & POLICIES**

In order to better serve you and obtain the best possible benefits from your dental insurance company, please carefully read the following and answer as accurately as possible. Don't hesitate to ask for help if you have questions. We will be happy to assist you.

**Person Responsible For This Account** _____

**Daytime Phone # (  ) _____- _____ Driver's License #** _____

**Responsible Person's Employer** _____

**DOB** _____ **SS#** _____

If you have dental insurance, please fill out below and please know that if you have a deductible that has not been met, or a copay, we expect payment at the time of service. We will estimate your copay to be 20% if you are not sure what it may be. We would like to make a copy of your card if you have one.

**Primary Carrier** ( subscriber - is the name of person on contract)
Employer _____
Subscriber Name _____
Does Subscriber Work for U.S. Government? Yes ☐ No ☐
Subscriber Birthday _____
Subscriber Daytime Phone # _____ Subscriber SS#_____
Contract # _____ Group # _____
Full Name of Insurance Co. _____
Address (if known) _____
Phone # (if known) (  ) _____

**Secondary Carrier** ( subscriber - is the name of person on contract)
Employer _____
Subscriber Name _____
Does Subscriber Work for U.S. Government? Yes ☐ No ☐
Subscriber Birthday _____
Subscriber Daytime Phone # _____ Subscriber SS#_____
Contract # _____ Group # _____
Full Name of Insurance Co. _____
Address (if known) _____
Phone # (if known) (  ) _____

We want you to understand that your dental plan probably will not cover the total cost of your services. Most plans pay between 50 & 80% of the total. You must consider that your maximum yearly benefit, copay and deductible (if any), all enter into the final payment estimation. We cannot always answer specific questions about your benefits or predict insurance coverage because plans may vary according to the contracts involved. Your employer (plan sponsor) is usually the best source to obtain specific information about your plan.

It is your responsibility to be familiar with the specifications of your insurance provider's coverage. Some restorative materials are covered at different levels by insurance providers. For example, composite (white) fillings and porcelain (white) crowns on back teeth may require more out-of-pocket expense than amalgam (metal) fillings and metal crowns.

**I have read the above and answered the questions to the best of my ability.**

**Signature** _____ **Date** _____

MONROVIA FAMILY DENTISTRY

## FINANCIAL POLICY

**Fees:** Fees are considered to be those prevailing in this dental community for the services of a general dentist. We will always be happy to discuss fees with you, and will provide an estimate of proposed fees for any procedure upon request.

**Appointment Cancellation Fee:** Appointments cancelled without 24 hours' notice or no shows are subject to a $20 fee per 30 minutes of scheduled appointment time.

**Payment:** We request payment for office charges and co-pays at time of service. In reference to your insurance, you are responsible for co-pays and deductibles depending on the type of insurance and insurance carrier. We accept cash, check, debit and credit card (MasterCard, Visa and Discovery) payments. If the insurance claim has not been paid within 60 days, we ask that you pay the balance using one of the above payment methods.

**Finance Charges:** If an account balance has not been paid within 60 days from the date of service or from payment or non-payment of insurance, we will begin charging finance charges of 1.5% per month (18% annually) on the unpaid balance. Finance charges will accrue each month on the unpaid balance until payment is received in full.

**Collection Practices:** You agree, in order for us to service your account or collect monies you may owe, Monrovia Family Dentistry, and/ or our agents may contact you by telephone at any telephone number associated with your account, including cell phone numbers, which could result in charges to you. We may also contact you by sending text messages or email, using any email addresses you provide to use. Methods of contact may include using prerecorded/ artificial voice messages and/ or use of automatic dialing devices, as applicable.

**It should be understood that your insurance policy is an agreement between you and your insurance company, your dental bill is an agreement between you and your dentist. You are responsible for full payment, regardless of the status of your insurance claim.**

Insurance companies have a schedule of fees, which they will pay. Your dentist's fee may be more or less than the schedule of fees of your insurance company. However, you are responsible for the FULL payment of your account and for questioning your insurance company about delays in payment and the amounts they pay. In the event we turn your account over to a collection agency or attorney for collection, you will be responsible for the collection agency fees (33.33%), and/or court cost and reasonable attorney fees.

If you have any questions about payment options or financial responsibilities, please contact our office.

**I/we have read, understand and agree to the provisions of this financial policy.**

_____ _____

**Signature of Patient or Person Financially Responsible** **Date**

**MONROVIA FAMILY DENTISTRY**
1920 SLAUGHTER ROAD
MADISON, ALABAMA 35758
(256) 830-2095

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse To Sign This Acknowledgement*

I _____ have received a copy of this office's Notice of Privacy Practices.

_____
Print Name

_____
Signature

_____
Date

**FOR OFFICE USE ONLY**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

This form does not constitute legal advice, and covers only federal, not state, law in effect or proposed as of August 14,2003. Subsequent law changes may require Form revision.

## *PATIENTS RIGHTS*

***Access:*** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed in this Notice. We will charge you a reasonable cost based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address in this Notice.

***Disclosure Accounting:*** You have the right to receive a list of instances in which we or our business associates disclose your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period we may charge you a reasonable, cost based fee for responding to these additional request.

***Restrictions:*** You have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

***Alternative Communications:*** You have the right to request that we communicate with you about your health information by alternative means, or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

***Amendment:*** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.



# MONRIVIA FAMILY DENTISTRY

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give this Notice about our privacy practices, and our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect 4/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed in this notice.

## *QUESTIONS AND COMPLAINTS*

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you alternative means or locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the Office for Civil Rights. We will provide you with the address to file your complaint with the Office for Civil Rights upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with the Privacy office or with the Office for Civil Rights.

Telephone: (256) 830-2095 Fax (256) 830-2021

Address: 1920 Slaughter Road

Madison, AL 35758

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

## *USES AND DISCLOSURES OF HEALTH INFORMATION*

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

### ***Treatment***
We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

### ***Payment***
We may use and disclose your health information to obtain payment for services we provide to you.

### ***Healthcare Operations***
We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

### ***Your Authorization***
In addition to our use of your health information for treatment, payment of healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

### ***To Your Family and Friends***
We must disclose your health information to you, as described in the Patients Rights Section of this Notice. We may disclose health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment of your healthcare, but only if you agree that we may do so.

### ***Persons Involved In Care***
We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use of disclosure of your health information, we will provide you with an opportunity to object to such use or disclosure, in the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

### ***Marketing Health-Related Services***
We will not use your health information for marketing communications without your written authorization.

### ***Required By Law***
We may disclose your health information when we are required to do so by law.

### ***Abuse or Neglect***
We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of others.

### ***National Security***
We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody or protected health information of inmate or patient under certain circumstances.

### ***Appointment Reminders***
We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, postcards or letters).