Your Name: _____

Creve Coeur Dental

Today is Your Day to Smile!

New Patient Package

Contents

How did you hear about Creve Coeur Dental?

PATIENT INFORMATION:

Last Name: _____ First Name: _____ MI: _____

Street Address: _____ City/State: _____ Zip: _____

E-Mail Address: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

Date of Birth: _____/_____/_____ Social Security #: ___ ___ ___ - ___ ___ - ___ ___ ___

Marital Status: Minor ☐ Single ☐ Married ☐

Employer Name:

Street Address: _____ City/State: _____ Zip: _____

Emergency Contact: _____ Telephone: _____

PERSON RESPONSIBLE FOR BILL:

Last Name: _____ First Name: _____ MI: ____

Street Address:_____ City/State: _____ Zip: _____

Date of Birth: _____/_____/_____ Social Security #: ___ ___ ___ - ___ ___ - ___ ___ ___

INSURANCE INFORMATION:

Primary Insurance Co.: _____ Telephone #:_____

Policy Number:_____ Group Number:_____

Insured's Name: _____ Date of Birth: _____/_____/_____

Relation to Patient: _____

Secondary Insurance Co.: _____ Telephone #:_____

Policy Number:_____ Group Number:_____

Insured's Name: _____ Date of Birth: _____/_____/_____

Relation to Patient: _____

INJURY RELATED INFORMATION:

ONLY COMPLETE IF APPLICABLE

Injury Date: _____/_____/_____ Area Involved: _____

Location of Accident: _____

Is an attorney involved: ☐/☐ If yes please provide name and number:_____

Have you ever been involved in a medical malpractice lawsuit: Yes _____ No _____

AUTHORIZATION AND RELEASE:

Assignment of Benefits and Simple Release of Patient Health Information

I authorized the release of all medical information necessary to process this claim and which is pertinent to my medical care. I authorize and request my insurance company to pay directly to CREVE COEUR DENTAL LLC insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered.

Patient/Guarantor Signature _____ Date: _____/_____/_____

HEALTH HISTORY OF PATIENT

Name: m_____ **DOB**:_____/_____/_____

Today's Date: _____/_____/_____ **Age**: _____ **Sex**: ◯Male ◯Female

Ethnicity: ◯ Caucasian ◯ African-American ◯ Asian ◯ Asian Sub-Continent ◯ Arabic ◯ Hispanic

Health History of Patient	Yes	No
Stroke	◯	◯
Heart Trouble	◯	◯
Diabetes	◯	◯
Arthritis	◯	◯
Gout	◯	◯
Seizures	◯	◯
Mental Illness	◯	◯
Kidney Trouble	◯	◯
Kidney Stones	◯	◯
Cancer	◯	◯
Bleeding Disorders	◯	◯
Alcoholism	◯	◯
Serious Injuries	◯	◯
Lung Disease	◯	◯
Tuberculosis	◯	◯
Phlebitis	◯	◯
Anemia	◯	◯
Stomach Ulcers	◯	◯
Liver Trouble	◯	◯
Thyroid Trouble	◯	◯
Other Illnesses	◯	◯
Explain ALL YES Answers		
Surgical Procedures mo/yy		
Current Medications		

Allergies to Medicine or Metal
Family History Immediate Family

	Yes	No
Stroke	◯	◯
Heart Trouble	◯	◯
High Blood Pressure	◯	◯
Diabetes	◯	◯
Arthritis	◯	◯
Gout	◯	◯
Seizures	◯	◯
Mental Illness	◯	◯
Kidney Trouble	◯	◯
Kidney Stones	◯	◯
Cancer	◯	◯
Bleeding Disorders	◯	◯

Social History
Most Recent Occupation:
Married ◯ Single ◯
Divorced ◯ Widowed ◯
Number of Children:
Presently Living Alone: ◯Y ◯N
Smoke: None ☐
Packs per day: X years
Alcohol: Never ◯ Occasional ◯
Moderate to Heavy ◯
Drugs: None ◯ Presently ☐
Presently ☐ Past Problem ☐

Have you had or have?	Yes	No
Reading Glasses	◯	◯
Change in Vision	◯	◯
Loss of Hearing	◯	◯
Ear Pain	◯	◯
Hoarseness	◯	◯
Nosebleeds	◯	◯
Difficulty Swallowing	◯	◯
Morning Cough	◯	◯
Shortness of Breath	◯	◯
Chills or Fever	◯	◯
Heart or Chest Pain	◯	◯
Abnormal Heartbeat	◯	◯
Badly Swollen Ankles	◯	◯
Calf Cramps	◯	◯
Poor Appetite	◯	◯
Toothache	◯	◯
Gum Trouble	◯	◯
Nausea or Vomiting	◯	◯
Stomach Pain	◯	◯
Ulcers	◯	◯
Frequent Belching	◯	◯
Frequent Loose Bowels	◯	◯
Frequent Constipation	◯	◯
Hemorrhoids	◯	◯
Frequent Urination	◯	◯
Blackouts	◯	◯
Seizures	◯	◯
Hot or Cold Spells	◯	◯
Recent Weight Changes	◯	◯
Nervous Tension	◯	◯
Women Only:		
Pregnancy	◯	◯
Irregular Periods	◯	◯
Vaginal Discharge	◯	◯
Frequent Spotting	◯	◯

Patient Signature _____ Date: _____/_____/_____

LIFETIME AUTHORIZATION INSURANCE ASSIGNMENTS & AUTHORIZATION TO RELEASE INFORMATION

I. TREATMENT OF INFORMATION - I hereby give Creve Coeur Dental consent for medical treatment.

II. RELEASE OF INFORMATION - I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payer (such as an insurance company or governmental agency, example: Blue Shield of Florida or Delta Dental of Missouri) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

III. PHYSICIAN INSURANCE ASSIGNMENT - I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

IV. I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. This assignment will remain in effect until revoked by me in writing. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for my insurance or third payer within a reasonable period of time not to exceed 60 days. I understand that I will be responsible for all collection fees; these fees will be added to the balance due and could exceed 35% of the original balance. If this account is assigned to an attorney or collection agency for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

DATE : _____/_____/_____ PATIENT: _____
Signature

SUBSCRIBER (if different from patient): _____
Signature

ORIGINAL SIGNATURE ON FILE AT PHYSICIAN'S OFFICE

FINANCIAL POLICY

Our health care team is committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance, and your understanding of our payment policy. Please be sure to ask any questions you may have regarding this financial agreement, as this will become part of your record.

PAYMENT FOR SERVICE IS DUE AT THE TIME SERVICES ARE RENDERED.
We accept cash, personal checks, MasterCard, Visa, and Discover. Returned checks less than $300.00 are subject to a service charge of $35.00. Checks greater than $300.00 will be charged accordingly.

CANCELED APPOINTMENTS
Patients who no-show appointments may be discharged from the practice after the third occurrence. Please call to cancel appointments 24 hours prior to scheduled time.

MEDICAL RECORDS
There will be a $30.00 administration fee for each medical records request. Your request will be responded to within 14 business days.
Patients may request a rush on their records for an additional $20.00 fee. The rush request will be available within 3 business days.

INSURANCE
Co-payments, Co-Insurance, and Deductibles must be paid at the time of service. As a courtesy to you we will file your insurance claim.

WORKERS' COMPENSATION
We will file your claim with your company's insurance carrier. In the event you fail to prosecute the claim for Workers' Compensation (for this illness or condition) or it is determined by the Workers' Compensation Board that this illness or condition is not a result of a compensable Workers' Compensation case, you agree to pay the standard fees for services rendered to you in this case.

CHILD OF DIVORCED PARENTS
Payment is due at the time of service no matter who is responsible by order of the divorce decree.

FINANCIAL AGREEMENT
We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance activity. You must realize, however that:

1. Your insurance is a contract between you, your employer, and the Insurance Company. We are not party to that contract.

2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

FINANCIAL POLICY (continued)

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company. **ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.**

We realize that emergencies do arise and may affect timely payments of your account. If such extreme cases do occur, please contact us promptly for assistance in the management of your account.

If you have any questions or any uncertainty regarding your insurance coverage, please do not hesitate to ask us. We will assist you accordingly.

I have read and understand the above two page Financial Policy.

DATE : _____/_____/_____ PATIENT: _____
Signature

DATE : _____/_____/_____ WITNESS: _____
Signature

CONSENT TO RELEASE OF RECORDS AND INFORMATION CONTEMPLATED BY HIPAA

Name: _____ DOB:_____/_____/_____

Today's Date: _____/_____/_____

As a patient of Creve Coeur Dental (C.C.D. LLC), I recognize that the Health Insurance Portability and Accountability Act of 1996 (HIPPA), public law 104-191, constitutes a comprehensive act of protection to ensure the security and confidentiality of my protected health care and account information. I further recognize that C.C.D. LLC, is maintaining protected health information and my patient account record with respect to my care and treatment.

By my signature appearing below, I agree, acknowledge, and understand that from time to time it will be necessary for C.C.D. LLC to transmit certain information about my care, treatment, operations, payment and account to third parties so as to assist in my health care, to protect my health and well-being, and to facilitate the timely and orderly billing and payment for the services I am receiving from C.C.D. LLC

With this acknowledgment and understanding in mind, and by my signature appearing below, I am specifically consenting to the release, electronic and other transmissions of information with respect to treatment, payment, or healthcare operations regarding my care, treatment and services provided by C.C.D. LLC, except that, I request that the following persons or entities not be provided this information unless and until I provide a specific authorization for such release:

_____
_____
_____

I reserve the right to revoke this authorization and/or consent during the term of my care or, at any time, but acknowledge that such revocation of authorization will be required to be in writing and signed by me, dated, and delivered to C.C.D. LLC. With these acknowledgments and agreements in mind I voluntarily and knowledgeably consent to the foregoing agreements, understanding and release of information when necessary.

_____ _____/_____/_____

Patient/Guarantor Signature Date

CONTACT INFORMATION

Name: _____ DOB:_____/_____/_____

Today's Date: _____/_____/_____

I wish to be contacted in the following manner (check all that apply):

___ Home Phone: _____
- ☐ Okay to leave message with detailed information
- ☐ Leave message with call-back number only

___ Cell Phone: _____
- ☐ Okay to leave message with detailed information
- ☐ Leave message with call-back number only

___ Work Phone:_____
- ☐ Okay to leave message with detailed information
- ☐ Leave message with call-back number only

___ Email: _____
- ☐ Okay to leave message with detailed information
- ☐ Please sign me up for electronic statements
- ☐ Send message with call-back information only

☐ Other:_____
_____
_____

All written correspondence will be mailed to your home address of record unless an alternate is given below:
Address:_____

_____ _____/_____/_____
Patient/Guarantor Signature Date

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use of, disclosure of, and request for PHI (Private Health Information) to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided here if completed properly, will constitute an adequate record.