Cedar Valley Family Dentistry

Kären Wilson D.D.S

General Patient Information

Title ________ Last Name ___________________ First Name_________________ Initial _____
Home Address: ____
City: _________________________ State: ______________________ Zip Code: ___________
Marital Status (circle): Single Married Divorced Widowed Sex (circle) Male Female
Social Security Number _________________ Date of Birth ________________
Email Address __________________________________ Occupation______________________
Home Phone Number _________________ Work Phone Number ________________
Cell Number _______________
If patient is a dependent, please list responsible person for account:
Parent/Guardian: _________________________
Address if different than above: ____
How did you hear of our office? Referral from friend? If so whom?_____________________
Yellow Pages Mailer Other? __________________________________

Financial Information

Primary Dental Insurance: Subscriber Name ____
Date of Birth _____________ Social Security Number _________________ Group # _________
Employer that provides insurance coverage: ____
Name of Insurance company ____
Address: _________________________________ City: ____________________ State: _________
Zip Code: ______________ Phone Number: ____________________
Single or Family Coverage? :_________________ Do You Have Secondary Coverage? ______

Secondary Dental Insurance: Subscriber Name _______________________________________
Date of Birth _____________ Social Security Number _________________ Group # _________
Employer that provides insurance coverage: ____
Name of Insurance company ____
Address: _________________________________ City: ____________________ State: _________
Zip Code: ______________ Phone Number: ____________________

I hereby certify that the foregoing information is accurate and compete and that in consideration of treatment and services rendered to me by this dental office, I am obligated to pay the office in accordance with its credit terms and policies.
Signature: ____ Date: ________________

Kären Wilson D.D.S

Emergency Contacts:

1. ______________________________ Phone:_____________________
2. _____________________________ Phone:______________________

Patient Dental History:

- Who was your previous Dentist?

  ____

- Do you have any current X-Rays?

  ____

- Month and Year of Last Dental Visit?

  ____

- What was done at your last visit?

  ____

- Are you currently in any Discomfort? If so, please circle all that apply)

Cold Sensitive	Hot Sensitive	Chewing Sensitive
Dull Ache	Swelling	Sharp Pain

- Does the discomfort keep you awake at night? Yes/No
- Do you experience TMJ (Jaw) discomfort?

  ____

List any medications you are taking for pain control:

- What do you like best about your smile?

  ____

- What would you change about your smile?

  ____

- What are your goals for your oral health?

  ____

- Are you interested in straightening your teeth?

  ____

Are you interested in hearing about our teeth whitening options? ____________________

Please Check the box if you have any of the following conditions:

☐ *Abnormal Bleeding	☐ *Allergy – Sulfa	☐ *Allergy – Penicillin	☐ *Angina Pectoris
☐ *Pacemaker	☐ *Pre Med – Amox	☐ *Pre Med – Clind	☐ * Pre Med – Other
☐ Alcohol Abuse	☐ Allergies	☐ Allergy – Aspirin	☐ Allergy – Codeine
☐ Allergy – Latex	☐ Allergy – Anesthetic	☐ Allergy – Jewlery	☐ Allergy – Metal
☐ Allergy – Erythromycin	☐ Allergy – Tetracycline	☐ Anemia	☐ Arthritis
☐ Artif. Heart Val	☐ Artificial Joints	☐ Asthma	
☐ Blood Transfusion	☐ Cancer – Chemo	☐ Congenital Heart Def	☐ Diabetes
☐ Dizziness	☐ Drug Abuse	☐ Emphysema	☐ Epilepsy
☐ Excessive Bleeding	☐ Fainting	☐ Fever Blisters	☐ Frequent Headaches
☐ Glaucoma	☐ Head Injuries	☐ Heart Attack	☐ Heart Murmur
☐ Heart Surgery	☐ Hepatitis	☐ High Blood Pressure	☐ HIV-AIDS
☐ Jaundice	☐ Kidney Disease	☐ Liver Disease	☐ Mitral Valve Prolapse
☐ Pregnancy	☐ Psychiatric Problems	☐ Radiation Therapy	☐ Respiratory Problems
☐ Rheumatic Fever	☐ Rheumatism	☐ Shingles	☐ Sickle Cell Disease
☐ Sinus Problems	☐ Stomach Problems	☐ Stroke	☐ Thyroid Problems
☐ Tuberculosis	☐ Tumors	☐ Ulcers	☐ Venereal Disease

Any Surgeries? If yes, please list type & date below:

Any disease, condition or problem you think this office should know:

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IMPORTANT

In order for us to give you the best care possible, it is important that we have your physicians name, phone number, & list of medications.

Physicians Name:

Physicians Phone:

Do You Smoke or use Tobacco?

Yes No

Height:

Weight:

Please List ANY Medications you are taking:

Have any family members had heart disease/high blood pressure/ diabetes? **Yes No**

Any family members snore, have sleep apnea, or a sleep disorder? **Yes No**

Do you suspect you have Sleep Apnea? **Yes No**

Have you ever participated in a sleep study? **Yes No**

If yes, were you recommended to use a C-PAP? **Yes No**

Are you interested in procedures for treating Snoring & OSA (obstructive sleep apnea)?

Yes No

Office Policies

Payment Policies

Payment is due at the time services are rendered.
We accept the following forms of payment:

- Cash
- Check- Local checks only, No starter checks
- Credit Cards- Visa, MasterCard, Discover

Financing is available with No Interest Options, with approved credit. (Citi Health Card.) Financing must be established before treatment is started. Please ask the Financial Coordinator for more details.

Appointment Policies

We certainly understand that occasionally, circumstances arise that prevents patients from keeping appointments. If you find it impossible to keep an appointment please call us 48 hours in advance during our business hours. As a courtesy, we strive to reach each patient by mail or telephone to remind them of their appointment. However, it is the patient's responsibility to keep track of their reserved time.

Cedar Valley Family Dentistry's policies regarding short notice cancellations (less than 48 hours) or failed appointments are:

For the first offense, our policy is to send you a letter reviewing office policies and a fee of $50.00 will be charged to your account per appointment missed. If missed appointment was in amount greater than $500, the fee will be $100.

For the second offense, our policy is to attempt to contact you by phone, and a fee of $50.00 will be charged to your account per appointment missed, if appointment was $500 or more a $100 fee will be charged to account. In addition, the original appointment time will not be rescheduled. For example: If you request highly requested appointment times, you will be given the next available time, which may not be early morning or late day times.

Finally, if a third offense occurs we will send a dismissal letter and you will no longer be seen in our office.

I have read and understand the above policies for Cedar Valley Family Dentistry. I will abide by these policies.
Signature: ____________________________________ Date: ____________________

FINANCIAL AGREEMENT FOR THE OFFICE OF KAREN C. WILSON, DDS

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employer, and the insurance company. Our practice is not a party to that agreement. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our practice by signing the authorization on the Assignment of Benefits Agreement. In order for our practice to file your insurance claim, you must bring your proof of insurance at each appointment.

Your **estimated** copayment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. Your **estimated** copayment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. Our practice accepts cash, personal checks, MasterCard, Discover and Visa. Third party, extended payment financing is available upon request and approval.

In order to reserve appropriate time for considerable treatment that exceeds $500.00, we require a minimum of a $50 down payment of your estimated co-payment, which is due at the time of scheduling. The remaining estimated co-payment will be due at the time services are rendered. In addition, highly requested appointment times: (8:00am and 4:00pm) appointment times will require a $50 deposit at the time of scheduling to reserve your appointment time. The amount applied to your account will be non-refundable in the event that you are unable to honor your appointment with us. A missed appointment fee may be applied as well.

Returned checks and balances older than 30 days will be subject to collection fees and finance charges at the rate of 1.8% per month (21% annually).

Additionally, our practice will charge you for appointments that you do not keep and for appointments that you do not cancel with 48-hours notice.
Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care.

Name of Patient or Responsible Party: ___________________ Date: ________________

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ____

Address: ____

Telephone: ______________________ E-mail: ______________________

Patient Number: ______________________ Social Security Number: ______________________

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. Kären Wilson

Telephone: 378-8833

Fax: 378-8849

E-mail: cedarvalleyfd@hotmail.com

Address: 1145 Linden Drive Marion, IA 52302

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ______________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: ______________________________ Date: ______________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ______________________________

Relationship to Patient: ______________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ______________________________ Date: ______________________

Assignment of Benefits Agreement

Our practice will accept an assignment of benefits from your insurance company with the conditions listed below. It is important to understand, though, that the agreement regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for all treatment and services we provide to you, 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 save you time and to facilitate payment to our practice from your insurance company. By having our practice 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 agreement 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 practice.
- We require you to pay the **estimated** copayment, which is the amount not covered by your insurance company, at the time we provide service to you. The copayment is only an **estimate** of charges and may be found to be insufficient after review by your insurance company.
- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our practice within 60 days, we will ask you to pay the entire balance at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
- Our practice 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 practice 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 to our practice.

I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THIS ASSIGNMENT OF BENEFITS AGREEMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE PRACTICE.

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Print Name of Patient or Responsible Party

__________________________________ __________________________________
Signature of Patient or Responsible Party Date