Dental Partners of North Georgia

Name_____DOB_____Age_____Sex_____SS#_____

Address_____City_____State_____Zip_____

Home # _____ Work #_____ Mobile# _____

E-mail Address_____ Who may we thank for referring you? _____

Employer_____ Work _____ EXT_____

Dental Insurance_____ Secondary Insurance_____

Spouse/Parent /Guardian (Circle One)

Name _____DOB_____SS#_____

Employer_____Address_____Work#_____

Your current Medical History Personal Physician Name_____ Phone #_____

Are you currently under the care of a Physician? Yes _____ No _____ Explain_____

Recent Hospitalization? _____Do you smoke or use tobacco products? Yes ____ No ____

Have you had any Metal rods, Pins or Implants? Yes _____ No _____ Do you snore? Yes ____ No ____

Is snoring a problem for you and your relationship? Yes _____ No _____

Are you taking any Prescriptions or Over-the-counter Drugs? Yes _____ No _____

Please List each one_____

Are you allergic to any Drugs/Materials? _____

Your Current Dental Health is Good__Fair__Poor__ Are your teeth sensitive to heat/cold or anything? Yes __No__

Do your gums bleed? Yes _____ No _____ Have you ever had gum Disease? Yes _____ No _____

Date of last Dental Visit_____ Procedure_____

In case of Emergency Call Name _____ Phone #_____

Have you ever had any of the following Conditions?

Y N Abnormal Bleeding
Y N Aids
Y N Alcohol/Drug abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones/Joints
Y N Artificial Valves
Y N Asthma
Y N Blood transfusion
Y N Cancer/Chemotherapy
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Recent Weight Loss
Y N Epilepsy
Y N Fainting spells
Y N Frequent headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart attack/Surgery
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis/Jaundice
Y N Herpes/Fever Blisters
Y N High Blood Pressure
Y N HIV
Y N Kidney Problems
Y N Liver disease
Y N Low Blood pressure
Y N Other_____
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/ Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Sexually transmitted Disease
Y N Heart Disease
Y N Are you pregnant

Signature X _____ Date _____

Dental Partners of North Georgia

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 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 you may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Completing Insurance forms is a courtesy we extend to you in an effort to 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 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 co-payment, which is the amount not covered by your insurance company, at the time we provide service to you. The co-payment is only an estimate of charges and may be adjusted after the time of treatment depending upon final reconciliation of insurance payment.
- Insurance payments are normally received with-in 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.
- Our Practice does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routing 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 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.

_____

Print name of patient or responsible party

_____ _____

Sign name of patient or responsible party Date

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. We are also committed to providing you with up-to-date info and educational tools so that you may participate in maintaining optimum oral health. This financial policy is intended to facilitate our ability to provide excellent service while minimizing administrative costs.

_____As a courtesy we "file" all insurance for our patients. The authorization for assignment of benefits agreement is for Insurance payments payable directly to Dental Partners. For us to file your Insurance claim, you must bring Proof of Insurance to each appointment. If payment isn't received within 60 days from the date of service with all efforts exhausted for request of payment, we will close the claim. The balance then becomes patient responsibility. Necessary Info will be provided to you for appeal with your Insurance carrier.

_____An **Estimate** of coverage based on the information received from your Insurance carrier will be provided on the day of service. The Difference/copayment will be your responsibility due on the day services are rendered. Any difference upon final reconciliation of Insurance payments will be billed to you payable upon receipt. We accept cash, check, or credit. Extended payment financing available through Care Credit upon request and approval.

Insurance Direct Reimbursement to the patient/Non-Assignment of benefits to the provider

_____Payment in full is collected on the day services are rendered. Our practice will file your Insurance as a courtesy for your direct reimbursement. Because the insurance will NOT pay the provider and will ONLY pay the policyholder, you are required to pay in full at the time of service

_____ **Emergency patients**–Payment Is expected at the time of service. We will file your Insurance as a courtesy. Once you are a patient of record, then only your copayment estimate will be due on day services are rendered.

_____ **Minors with divorced parents.** The parent that brings the child is responsible for the entire bill **unless a court order is on file**. You will be responsible for reimbursement from the other parent.

_____**NSF/Returned Checks-**There will be a $30 processing fee for a returned check. We reserve the right to no longer accept payment by check for future services.

_____ **Missed appointments**- Our practice will charge a fee for no-show appointments and/or cancellation of appointments without a 48hour notice.

_____**Delinquent accounts** with a balance over 90 days will be turned over for collection thru a collection agency. You will be contacted by the agency for collection of your balance. This is not a pleasant experience for either party. We will reserve the right for continued services.

_____**** I have read and accept the terms and conditions of this financial policy****

Print Name _____

Sign Name _____ Date_____