Hoek Esthetic Family Dentistry

Patient Information Form

Date_____

Name_____
Last First Middle Initial

SS#_____ DOB_____ Sex_____

Home Phone_____ Cell Phone_____

Email_____

Address_____
Street

_____
City State Zip

Child_____ Single_____ Married_____ Separated_____ Divorced_____ Widowed_____

Emergency contact_____ Phone_____

Employer_____

Business Address_____

Occupation_____ Business Phone_____

Reason for today's visit _____

Previous Dentist_____ Date of last exam_____

Phone _____ Date of last X-rays _____

Address _____

I allow the following individuals to discuss my financial, medical and/or dental information with employees of Hoek Esthetic Family Dentistry.
Print full names_____, _____

Who should we thank for referring you? _____

INSURANCE INFORMATION

Subscriber Name_____ SS#_____

Relationship to patient_____ Subscriber's Birthdate_____

Address_____ Home Phone_____
Street

_____
City State Zip

Employer_____ Date employed_____

Business Address_____ Work Phone_____
Street

_____
City State Zip

Insurance Company Name_____

Group #_____ Subscriber ID#_____

Ins Co Address_____
Street City State Zip

Ins Co Telephone # _____

It is important to understand that your actual insurance benefits may differ from the benefits estimated in your Treatment Plan Estimate. Your Treatment Plan Estimate is based on information provided by you and your insurance company. Please remember that it is only an estimate and your benefits may be higher or lower than what is estimated. In all cases, the cost of all dental care is ultimately the responsibility of the patient or their legal guardian, regardless of insurance coverage. Therefore, you are responsible for amounts not covered by your insurance, unless prohibited by law or contractual agreement. We encourage all patients to refer to their member handbooks or call their plan administrator with any questions or concerns relating to specific benefits.

I hereby authorize payment directly to Hoek Esthetic Family Dentistry, Inc for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of responsible party_____ Date_____

MEDICAL INFORMATION

Physician_____ Office Phone_____ Date of last exam_____

Are you currently under medical treatment? _____ yes _____ no If yes, please add to "Notes" section.

Do you use tobacco? _____ yes _____ no In what form? _____ How much? _____ How long? _____

Have you ever used or are you currently using any recreational drugs? _____ yes _____ no

Do you have any drug, latex, metal or food allergies? _____

Are you taking or have you taken oral bisphosphonates? (e.g. Fosamax, Actonel, Boniva, Didrone, Aredia, Zometia, Skelid?

Women only: Are you pregnant?_____ Nursing?_____ Taking birth control?_____

Please circle if you have had or have any of the following:

Abnormal bleeding*	Epilepsy	Mitral valve prolapse*
Alcohol/Drug Abuse	Fainting spells	Pneumocystis
Anemia	Fever blisters	Pre-Med
Angina pectoris	Frequent headaches	Psychiatric problems
Arthritis	Glaucoma	Radiation therapy
Artificial joints*	Heart attack*	Rheumatic fever*
Artificial heart valve*	Heart disease*	Seizures
Asthma	Heart surgery*	Sickle cell disease
Cancer/chemotherapy*	Hepatitis*	Sinus problems
Colitis	HIV or AIDS*	Stents/shunts*
Congenital heart defect*	High blood pressure*	Stroke*
Defibrillator/Pace maker	TMD/ Jaw problems	Thyroid problems
Diabetes*	Kidney problems	Tuberculosis
Difficulty breathing	Liver disease	Ulcers
Emphysema	Low blood pressure	Venereal disease

* May need physician clearance prior to dental treatment

Are you currently taking any medications? _____ yes _____ no If yes, please list:

Is there any disease, condition, or problem that was not specifically addressed above that you think this office should know about? If yes, please describe below:

Notes:

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge.

Signature_____ Date_____

(If under 18 parent or guardian signature required)

SMILE EVALUATION

1. Do you like the way your teeth look? Yes No

   Explain:_____

2. Are you happy with the color of your teeth? Yes No

   Explain:_____

3. Would you like for your teeth to be whiter? Yes No

   Explain:_____

4. Would you like your teeth to be straighter? Yes No

   Explain:_____

5. Do you have spaces between your teeth that you would like closed?
   Yes No

   Explain:_____

6. Would you like your teeth to be longer? Yes No

   If so, Upper___ Lower____ Both_____?

7. Do you like the shape of your teeth? Yes No

   Explain:_____

8. Do you have missing teeth that you would like to replace?
   Yes No

   Explain: _____

9. If you could change anything about your smile, what would you change?

   _____

   _____

PATIENT AGREEMENTS

Financial Responsibilities:
Payment in full of the estimated patient portion is due at the time of treatment! Please do not hesitate to ask for a pre-treatment estimate. The Treatment Plan Estimate is a good faith attempt to predict the costs of your treatment based on the information known at the time of the estimate.

Accepted Forms of Payment:
Hoek Esthetic Family Dentistry accepts cash, personal checks, Visa, Mastercard, Discover, assigned insurance benefits and approved third-party financing.

Third Party Financing:
Hoek Esthetic Family Dentistry offers treatment financing through CareCredit. Hoek Esthetic Family Dentistry pays this company fees for making loans available to patients and for the lender's cost of servicing these loans.

Collection Policy:
If your account becomes delinquent and no financial arrangements have been made, you will be responsible for legal fees, interest charges, 33 1/3% attorney fees, and any other expenses incurred in collecting your account balance. All work must be paid in full at the time of service once your account has been satisfied with the attorney.

Missed Appointments/Cancellation Policy:
Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best service to our patients, we require at least 2 business days notice for cancellations or rescheduling of your appointments. We understand that unforeseen circumstances may arise, which may result in cancelling or missing your appointment, however, a charge may be assessed for multiple missed or short notice cancelled appointments. Multiple failed appointments may result in being dismissed from the dental practice.

X-Rays:
We pride ourselves in delivering the highest standard of care; therefore complete diagnostic x-rays are required for our new patients. If you have had this series in the past three years, we ask that you bring them with you on your initial visit. If you do not have them or are not able to retrieve them from your prior dentist before your appointment with us, we will need to take X-rays and charge accordingly.

Notice to Test Blood:
A law was enacted in Virginia in 1989 which authorized health care providers to test their patients for HIV antibodies when the health care provider was accidentally exposed to blood or body fluids in a manner which may transmit HIV. However, you would be informed before any of your blood would be tested. The testing would be explained and you would be given the opportunity to ask any questions you might have. In addition, in the event that one of our health care providers is exposed to potentially infectious body fluids permission is hereby granted to test my blood for infectious Hepatitis B.

Patient Authorization:
I agree to and understand the above statements. Furthermore, I understand that it is my responsibility to inform this office of any changes to the information I have provided. I, the undersigned do hereby fully authorize to examine, to treat and to care for me as decided upon and deemed necessary. I realize and adopt the risks involved.

Signature_____ Date_____

HIPAA PRIVACY POLICY

1. Purpose
    a. This notice describes how medical information we collect and maintain about you may be used and disclosed and how you can get access to this information.
    b. Our responsibility is to maintain the privacy of your health information strive to protect it as required by law.

2. Scope – This policy applies to all employees, management, contractors, student interns, and volunteers authorized to enter information into your medical record.

3. Your Health Information Rights: The health and billing records we maintain are physical property of the practice. The information in it, however, belongs to you.
    a. Right to Request Restrictions – You may request restrictions on certain uses and disclosures of your health information in writing. We are not required to grant the request but will comply with any request granted.
    b. Right to Request Confidential Communications
    c. Right to Inspect – You may inspect and copy your health or billing record.
    d. Right to Amend – If any information obtained is incomplete or incorrect, a written amendment request can be made.
    e. Right to Request Information or File a Complaint – If you would like additional information or want to report a complaint regarding the handling of your information, you may do so.

If you wish to exercise any of the above rights, please contact Meredith Hoek, DDS in person or in writing. She will provide you with steps to take.

4. We participate with the Virginia Prescription Monitoring Program and reserve the right to pull a report if necessary. How We May Use and Disclose Health Information:
    a. For Treatment
    b. For Payment
    c. Workers Compensation
    d. As required during an investigation by law enforcement agencies
    e. As required by military command authorities for their medical records
    f. In response to a legal proceeding
    g. To a coroner or medical examiner for identification of a body
    h. Other – any other use or disclosure deemed necessary besides those identified in this Notice will be made only as required by law or with your written authorization

Changes to this notice

We reserve the right to amend, change or eliminate provisions in our privacy practices and access practices to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our Notice or by visiting our office and picking up a copy. Any notice changes will be posted at office location.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, hereby acknowledge that I have received a copy of this office's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____
Printed Name

_____
Signature

_____
Date