Dentistry at Greenway

PATIENT INFORMATION

Name _____ Birthday _____ SS# ____ _____

Address _____ City_____ State_____ Zip _____

Sex M F Married ____ Widowed____ Single____ Divorced____ Minor____

E-Mail _____ Home Phone _____ Cell Phone _____

Employer/School _____Employer/School Phone _____

Employer Address _____

Spouse or Parent Name_____ Employer _____ Work Phone_____

Whom may we thank for referring you? _____

Person to contact in case of emergency: _____ Phone _____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home phone _____

Driver's License # _____ Birthday _____

Employer _____ Work Phone _____

Currently a Patient in our office? Yes No E-Mail _____

INSURANCE INFORMATION

Name of Insured _____ Relationship to patient _____

Birthday _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone _____

Employer Address _____ City_____ State_____ Zip _____

Insurance ID# _____ Insurance phone # _____

Dental History

Reason for today's visit _____Date of last Dental Care _____

Former Dentist _____ Date of last Dental X-Rays_____

Address _____

Check if you have had any of the following:

_____Bad Breath _____Grinding teeth _____Sensitivity to hot _____ Sensitivity to Sweets _____Periodontal Treatment

_____Bleeding Gums _____Loose Teeth _____Sensitivity to cold _____ Sensitivity when biting _____Broken Fillings

_____Clicking or popping jaw _____Food Collection between the teeth _____Sores or growths in your mouth

How often do you floss? _____How often do you brush? _____

Medical History

Physician's Name and Address _____Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "Fen-Phen"? These include combinations of lonimin, Adipex, Fastin (brand names of Phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine) Yes No

Have you had any serious illnesses or operations? ____Yes ____No If Yes, describe _____

Have you ever had a blood transfusion? ____Yes ____No If Yes, approximate date _____

Women: Are you pregnant? ____Yes ____No Nursing? ____Yes ____No Taking Birth Control? ____Yes ____No

Please circle if you have had any of the following:

Anemia	Congenital Heart Disease	Rheumatic Fever	Scarlet Fever	Arthritis, Rheumatism	Hepatitis
Hernia Repair	Cortisone Treatments	Shortness of Breath	Artificial Joints	Cough, Persistent	Nervous Disorder
Skin Rash	High Blood Pressure	Artificial Heart Valves	Coughing up Blood	Ulcer	HIV/AIDS
Stroke	Asthma	Diabetes	Jaw Pain	Back Problems	Heart Problems
Epiliepsy	Swelling of Feet or Ankles	Kidney Disease	Thyroid Problems	Bleeding Abnormally	Fainting
Liver Disease	Tobacco Habit	Blood Disease	Glaucoma	Mitral Valve Prolapse	Cancer
Tonsillitis	Headaches	Pacemaker	Tuberculosis	Chemical Dependency	Radiation Treatment
Heart Murmur	Chemotherapy	Respiratory Disease	Venereal Disease	Circulatory Problems	

Do you take Bisphosphonates YES or NO

List the medications you are currently taking and the correlating diagnosis **Allergies**

_____ _____

_____ _____

_____ _____

Authorization and Release

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have changes in health. I certify that I and/or my dependant(s) have insurance coverage with _____ and have assigned directly to Dentistry at Greenway all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by the insurance or not. I authorize the use of my signature on all insurance submissions. The above named facility may use my health care information to the above named Insurance Companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the dates signed below.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date

Payment is due in Full at time of treatment unless prior arrangements have been approved.

PATIENT FINANCIAL RESPONSIBILITIES

Patient Name:_____ DOB: _____ ACCT#: _____

Patient Financial Responsibility Policy Statement:
Dentistry at Greenway is pleased to provide you, our patient, with the highest level of care for your health and quality of life. We strive to employ the most professional staff and deliver services to you with the latest technology and education available each day. You and Dentistry at Greenway, together, will combine our energies to bring positive results to your dental care needs. Dentistry at Greenway in its continuous efforts to deliver the best in care requires payment of all known patient responsible balances at time of service. These balances may include but are not limited to co-pays, deductibles or co-insurance (amounts as stated in the benefits coverage contract with your insurance carrier); any amounts due for patients who are "self-pay"; any amounts due from previous dates of service, or amounts that may be incurred during your current visit. We understand that circumstances may preclude you from paying amounts due at time of service. Non-payment of amounts due may result in your scheduled appointment being rescheduled to a later time when you have funds available and/or the addition of administrative fees of fifteen dollars ($15.00) to your amount due if you are seen and are unable to pay. We regret that these fees are added but are necessary to help defray the costs of administrative time and staffing. We appreciate your understanding and cooperation to ensure that Best Choice Dental is able to continue to provide the highest level of services to all in need of our staff and facilities.

_____ (Initials)

Payment Policy: Payment is expected at time of service for any applicable co-pay, co-insurance, and/or deductible. Dentistry at Greenway accepts cash, checks, Visa, MasterCard, or American Express as forms of payment for your convenience. Failure to pay at time of service may result in re-scheduling of your appointment until funds are available to cover the service and an additional fifteen dollars ($15.00) for administrative fees to cover processing of your non-payment and billing. The fee estimate listed for this dental care can only be extended for a period of **six** months from the date of the patient examination.

_____ (Initials)

Insurance Policy: We will require a digital scan of your insurance card and driver's license at the time of your arrival. Dentistry at Greenway will bill your insurance company as a courtesy to you, but this billing service does not preclude your financial responsibility for the services received. Any deductible, co-insurance or non-covered services, including ineligibility are your responsibility. If Dentistry at Greenway is not contracted with your insurance provider, Dentistry at Greenway, as a courtesy, will submit claims to your carrier; any deductible, co-insurance or non-covered services, including ineligibility are your responsibility. Dentistry at Greenway will mail monthly statements and contact you to collect any open balances. Please inform our staff immediately of any insurance changes.

_____ (Initials)

Non-Covered Service Policy: Certain services performed by our office, for your benefit, are NOT COVERED by your insurance plan(s). Dentistry at Greenway suggests you contact your insurance carrier to verify your benefits and understand any non-covered services, as these will be your financial responsibility. Payment will be required prior to your appointment.

_____ (Initials)

Delinquent Accounts Policy: All past due balances shall bear an interest charge at the rate of one and one-half percent (1.5%) per month. Delinquent accounts will be reported to a collection agency following Dentistry at Greenway normal collection procedures to resolve any outstanding balances. If an account is reported to a collection agency, a collection fee of 36% will be added to any outstanding balance. Please inform our billing staff if you know your payment will be late in arriving or if you require payment arrangements. Any request for payment arrangements must be accompanied by a personal financial statement and IRS Tax Returns for the two most recent years.

_____ (Initials)

Attorneys' Fees/Costs: You shall pay for all costs and expense incurred by Dentistry at Greenway in connection with Dentistry at Greenway attempts to obtain payment, including fees charged by a collection agency or attorney, and any other charges which can be legally charged to you. You agree that for and in consideration of Dentistry at Greenway extension of credit that this agreement is to be construed under the laws of the State of Arizona, and that if legal action is brought to enforce this agreement, that Maricopa County, Arizona, shall be the exclusive jurisdiction and legal forum and venue for said action. If Dentistry at Greenway refers this agreement to an attorney for enforcement, including collection of amounts which are past due, you agree to pay Dentistry at Greenway actual attorneys' fees and costs incurred thereby, whether or not formal proceedings are brought to remedy your breach of this agreement.

_____ (Initials)

Late Arrivals: In order for our dentists to see their patients in a timely manner, your help in arriving promptly for your appointment is required. If you are more than 10 minutes late, our office will reschedule your appointment to a new date and time. Tardiness affects your patient care as well as those patients that have a scheduled time after you. We understand your time is valuable and will do our best to respect your time and see you as promptly as possible. Please be aware that sometimes certain situations and emergencies can occur and cause your provider to run late. Please be patient in these circumstances.

_____ (Initials)

Dental Records: Should you request a copy of your medical records, please allow our office 7-10 business days for completion. The charge for this service is ten cents ($0.10) per page.

_____ (Initials)

Forms Policy: Should you request our office to complete forms on your behalf for disability, work status, etc., there will be a charge of twenty-five dollars ($25.00) per form. Payment of this charge is expected at time of completion.

_____ (Initials)

Appointment Cancellations/No Shows/Reschedules: There is a forty dollar ($40.00) charge if you reschedule or no show for an appointment without giving 24 hours notice. These appointment times could have been given to another patient who needs dental care. We understand unusual circumstances can occur, at which time we ask that you please contact our office as soon as possible.

_____ (Initials)

Returned Checks: Our office charges a thirty-five dollar ($35.00) fee for all accounts closed, stop payment or non-sufficient funds returned checks.

_____ (Initials)

Referrals & Authorizations: If a referral is required by your insurance carrier you will be asked to obtain the referral prior to your appointment. If no referral exists on file or your referral has not been received, your appointment may be cancelled. Our office will obtain authorization for your procedure prior to scheduling your appointment. We suggest you contact your insurance carrier to verify your coverage, benefits and preauthorization requirements prior to having any procedures performed. Claims are paid based on dental necessity. Please be aware authorizations and referrals are not a guarantee of payment by your insurance carrier and remain your responsibility.

_____ (Initials)

Workmen's Compensation: Dentistry at Greenway will require you to inform us of any changes regarding your workers' compensation claim. The following information is required: adjuster's name, claim status (litigation, supportive care, claim closed, or new injury), DOI, carrier, claim number, and claims address. Please have this information available prior to your appointment time.

_____ (Initials)

_____ Date: _____
(Patient/Guarantor Printed Name)

_____ Date: _____
(Patient/Guarantor Signature)

Reviewed by: _____ Date: _____
(Staff member initials)

NOTICE OF PRIVACY PRACTICES

Dentistry at Greenway

16630 W Greenway Rd Suite 319

Surprise, AZ 85374

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment here at Dentistry at Greenway is to serve our patients with professionalism and caring, being sure at all times to PROTECT the privacy and security of all Protected Health Information.

During the course of serving your interests, it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to consult with a dental laboratory technician
- For payment purposes, we may use the services of a billing service
- During dental care, we may need to consult with your physician or previous dentist
- For payment purposes, we need to supply information requested from your insurance company

We here at Dentistry at Greenway are committed to obeying all Federal, State, and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. The individual, as provided by law, may revoke this written authorization at any time.

If you have any questions or comments regarding your Protected Health Information, feel free to contact our Office Manager.

I have read and understand the Notice of Privacy Practices.

Signed: _____ Date: _____

(Patient or Legal Guardian)

Dentistry at Greenway Advantage Plan Registration Form:

Today's Date ___/___/___

Name of Primary Person:_____ DOB_____

Primary Address:_____ Ph#_____

_____ Cell#_____

Email Address: _____

List of All Dependents(Dependents are those living in the home only)

Name:_____ DOB_____

Name:_____ DOB_____

Name:_____ DOB_____

Name:_____ DOB_____

If you have any other insurance please list information below.

Your dental insurance will be your primary Insurance. Any procedures not covered will default to the ADV plan or if you max out on your insurance we will default to the ADV plan

Insurance Company Name:_____

Policy Holder Name:_____

ID/SS#_____ DOB_____

Start date for Annual Fee_____

PT Signature_____