GATEWAYDENTAL

YOUR GATEWAY TO A HEALTHIER SMILE

FAMILY DENTISTRY - IMPLANT DENTISTRY - COSMETIC DENTISTRY

Patient Information

Patient Name: _____

Last First Middle

☐ Male ☐ Female

☐ Single ☐ Married Birth Date: _____ Social Security: _____

Address: _____

Street Apt

_____

City State Zip Code

Email Address _____

Phone (Home): _____ Work: _____ Ext: _____ Mobile: _____

Referral Information

Whom may we thank for referring you to our practice?

_____

Insurance Information

Insurance Plan Name _____

Name of Insured: _____

Last First Middle

Insured's Birth Date: _____ Insured's Social Security# _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

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Health Information

Date of Last Dental Visit: _____

Have you ever had any of the following? Please check ONLY those that apply:

- ☐ AIDS/HIV
- ☐ Allergies _____
  _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

Other:

- ☐ _____
- ☐ _____

- Are you taking any medication? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you allergic to any medication? ☐ Yes ☐ No
  If yes, please explain: _____

- Do you have any history of a major illness? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you had any major operations? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- (Women Only) Are You:
  Pregnant ☐ Yes ☐ No
  Nursing? ☐ Yes ☐ No
  Taking birth control pills? ☐ Yes ☐ No

Consent for Services

As a condition of treatment by Gateway Dental, financial arrangements must be made in advance. Gateway Dental depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. Gateway Dental will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, Gateway Dental cannot render services on the assumption that our charges will be paid by an insurance company.

I authorize Gateway Dental 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

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FINANCIAL POLICY

Welcome! Thank you for selecting *Gateway Dental* as your dental health care providers. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy.

FINANCIAL AGREEMENT:
Patients are expected to pay for our services at the time they are rendered. Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service. Payments may be made using cash, check, Visa, MasterCard and/or Discover. We also offer CARECREDIT and LENDING CLUB, which are financing options that are available only for healthcare expenses. We will mail monthly statements to all patients with an outstanding balance. (There will be a fee for any additional procedure NOT included in the original treatment plan.)

Optional payment terms:
1. Full pay cash discount: We offer a 5% accounting courtesy for all services over $1,000 that is paid in full prior to the commencement of services.
2. Financing: By arrangements with CARECREDIT /GREENSKY ETC. we can offer patients upon approval, an interest-free term loan with no down payment, no annual fee and no prepayment penalty. Ask for an application.
3. Refunds: You may discontinue treatment and request a refund at any time for any amount that you paid for treatment that you did not receive; provided, however, crown and bridge patients are responsible for the full cost of their treatment plan once preparation of your teeth has begun. All refunds are to be requested in writing. All pre-paid treatment may occur a minimum 15% cancellation fee. Refunds may take 30-90 days for processing.

Appointments:
In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. We require at least 24-hour notice for any cancelled appointment. After 2 missed appointments, we will charge a fee anywhere from $50-$100 depending on the allotted time of appointment.

Insurance Information:
As a courtesy to our insured patients, we submit claims to your insurance company free of charge. We will help you to receive your maximum allowable benefits. In order to do this we need your insurance card and/or insurance policy with you on your first visit of every calendar year (your insurance year may not run January – December) **All of our doctors will diagnose treatment based on your dental health not your insurance coverage.**
You must realize that: Dental insurance isn't really insurance (a payment to cover the cost of a loss) at all. It is actually a money benefit, typically provided by an employer, to help their employees pay for routine dental services. The employer usually buys a plan based on the amount of the benefit and how much the premium costs per month. Most benefit plans are only designed to cover a portion of the total cost of a person's necessary dental treatment. For example, a dentist may recommend a crown for a tooth that has extensive decay; however, the dental plan may only cover the cost of a filling. This does not mean that the patient does not need a crown, only that the benefit is limited to a filling.

If your insurance has not paid within 90 days of services rendered, you will need to make full payment to this office and reimbursed when your insurance company pays. After 90 days the patient is responsible to pursue payment from the insurance company. All current documentation will be provided by mail in order to assist your inquiries. **The insured has a better ability to deal with the insurance company and the employer responsible for the policy.**

Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are patients of the practice.

Patient's name (please print):_____

Patient's signature: _____ **Date:** _____

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ORAL CANCER SCREENING CONSENT FORM

Recent evidence suggests that oral cancer is on the rise and we want to take a more active role in increasing your awareness of the importance of oral cancer screening as well as provide the best possible care to our patients. With 36,000 Americans diagnosed yearly with oral cancer the dental office can be the first line of defense against cancer. There is a 90% chance of survival rate when detected early. We are seeing an increase in the HPV virus especially in the younger population so oral cancer screening is becoming more crucial every day. Oral cancer has the worst 5-year survival rate of any cancer but if it is recognized early, then the chance of a cure/survival is good. Late detection is one of the primary causes of increased mortality rates from oral cancer.

Risk factors - but not limited to the following:

Age – age 40 and older
Tobacco Use
Drinking alcoholic beverages
Oral HPV Virus – increasing in young adults

Even though you may not have any of the risk factors above, you are still at risk. CDC recommends an annual oral cancer screening exam. Any delay could put you at risk of oral cancer not being detected at an early stage as oral cancer is often painless in the early stages. With the advent of technology, we now have better tools to help spot cancer in its early stages. We have incorporated the Oral Cancer Dental Oral Exam system into our practice to provide better care to our patients. This system helps the doctor possibly identify an abnormality at an early stage. This is a painless exam that will take approximately 1-2 minutes. Dental Insurance Companies do not cover this procedure and will have a minimum cost of **$50.00.** I have read the above statements and have received a copy of them if requested, and recognize their importance in helping me make a decision. My signature indicates that I have read and understand this consent document. The risk and benefits have been explained to me. I have been given ample opportunity to ask questions. I understand that this is a screening tool and not a definitive diagnostic tool and no guarantees have been made to me

- I authorize the above exam.

- I decline to authorize the above exam and understand the risks of my decision.

Signed: Date:

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name: _____

Signature:_____

Date:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency prevented us from obtaining acknowledgement
- Other (Please Specify)

_____

_____

_____

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NOTICE OF PRIVACY PRACTICES

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.

This practice is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or health care operations. (example)

"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with this practice."

"It is our policy to provide a substitute health care provider, authorized by this practice, to provide assessment and/or treatment to our patients, without advance notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation"

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to this practice for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.