Auburn Dental SMILES

Scanned_____

Patient Information

Patient Name_____
Last, First MI (Preferred Name)

Gender ☐ Male ☐ Female Marital Status: _____

Social Security #: _____ Birth Date_____

Phone (Home): _____ (Cell): _____

Email: _____

Address:_____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit_____ Reason for this visit: _____

Do you have or have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ 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
- ☐ Pregnancy
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

OTHER:

- ☐ _____
- ☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any allergies that we need to be aware of? ☐ Yes ☐ No
  If yes, please list: _____

Medication List: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ / _____
Signature of patient, parent or guardian Date Dr. Signature Date

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Post Card ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name _____ Occupation: _____

Address: _____

Street City, State Zip Code Phone

Insurance Information

Primary

Insured's Employer Name: _____

Insurance Plan Name: _____

Member ID#: _____

Address: _____

Phone #: _____

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

Secondary

Insured's Employer Name: _____

Insurance Plan Name: _____

Member ID #: _____

Address: _____

Phone #: _____

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

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

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

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that 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.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

Navdeep Dhaliwal, DDS **and Associates**
Auburn Dental Smiles 253-833-2290

OFFICE POLICIES

Our goal is to provide you with the highest quality dental care in a fun, caring environment. We want to have a long-term relationship with each patient to provide a preventive dentistry program. To facilitate your treatment in our office, we will do our best to help you understand your investment in your dental health. In order to prevent any misunderstandings, please read this carefully. Your signature at the bottom indicates you are aware of our office procedures. We welcome any questions you may have.

Payment Options and Financing: Payment in full is expected at the time of service. To assist you with your investment in your dental health, we offer the following financial options for patients without dental benefits:

1. We accept Visa, MasterCard, Discover, American Express, Lending Club and CareCredit.
2. If you require an extended monthly payment plan, 3rd party financing is available.

Insurance Billing: Please provide us with your dental benefit plan information. We are happy to assist you in obtaining maximum dental benefits by preparing and submitting your claims. Please note that there are some plans in which we do not participate as a preferred provider. *We require payment of deductibles and coinsurance to be paid at the time of service.*

At your request, we will submit a copy of your treatment plan to your insurance carrier so that you can receive an estimate of benefits before starting treatment. However, it is important to note that this predetermination of benefits is not a guarantee of payment by your insurance carrier; and ultimately the total cost of your treatment is your responsibility. If the insurance carrier disputes payments, they will become the full responsibility of the patient after 90 days from the date of service. We cannot be responsible for collecting your insurance benefits or negotiating a settlement of a disputed claim, although we will do our best to assist you during the process.

Please read and initial the following:

_____**Finance Charges**: Account balances over 90 days from the date of service are subject to a 1% monthly finance charge.

_____**Appointment Reminders:** As a courtesy, we routinely call to remind patients of their appointments one to two days in advance. However, we do expect our patients to be responsible for keeping their appointment whether or not a reminder call was received.

_____**Appointment Changes:** Your appointment time is reserved exclusively for you and we appreciate your commitment to keep it. We do understand that at times an appointment must be changed, but require 24 business hours notice to avoid a $50/hour cancellation fee.

_____**Returned Checks:** There is a $25.00 charge for any returned checks.

Authorization: I have read, understand and accept the information presented above.

Signature Printed Name Date

Insurance Assignment and Release

I, the undersigned, have dental insurance, and assign directly to Navdeep Dhaliwal, DDS and or her associates all dental benefits, payable for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature Printed Name Date

Acknowledgement of Privacy Practices

Auburn Dental Smiles
1002 Harvey Rd, Auburn, WA 98002 Tel: 253.833.2290

My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- ✓ Provide and coordinate my treatment among a number of healthcare providers who may be involved in the treatment directly or indirectly.
- ✓ Obtain payment from a third-party for my healthcare services.
- ✓ Conduct normal healthcare operations such as quality assessment and improvement activities.

I have been informed of my dental providers Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the above address to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information may be used or disclosed to carry out treatment, payment or healthcare operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name_____Date_____

Signature_____

Relationship to Patient_____

I allow the following individuals to have access to my dental records:

_____

_____

_____

For Office Use Only:

We were unable to obtain patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:
The patient refused to sign _____
Communication Barriers _____
Emergency Situation_____
Other:_____