Patient Information

Last Name _____ **First Name** _____ **MI** _____

Sex (circle) **M** **F** Birthdate ____/____/____ SSN# _____

Address: Street _____

City _____ State _____ Zip _____

Email _____

Home # ( ) - Work # ( ) -

Mobile # ( ) -

Emergency Contact: _____

Phone # ( ) -

How did you hear about **Alpha Dental**?

□ Newspaper □ Radio □ TV □ Internet □ Referral □ Mailing □ Other: _____

Insurance Information

Do you have Dental Insurance? □ Yes □ No Is the Dental Insurance provided by MEDICAID? □ Yes □ No

Do you have a second Dental Insurance? □ Yes □ No

If you have both Private & Medicaid Dental Insurance, the Private insurance would be your PRIMARY Insurance

Medicaid Insurance			
Medicaid Insurance Plan		Medicaid Membership #	
Medicaid Member's Social Security #		Medicaid MMIS #	

Primary PRIVATE Insurance (PPO)		**Secondary PRIVATE Insurance (PPO)**	
Subscriber's Name (Policy Holder - Spouse? Parents?)		Subscriber's Name (Policy Holder - Spouse? Parents?)	
Subscriber SSN		Subscriber SSN	
Subscriber ID#		Subscriber ID#	
Date of Birth		Date of Birth	
Relation	□ Self □ Spouse □ Child □ Other	Relation	□ Self □ Spouse □ Child □ Other
Employer		Employer	
Employer Phone		Employer Phone	
Insurance Company		Insurance Company	
Insurance Group		Insurance Group	
Insurance Phone		Insurance Phone	

Please present insurance card and photo ID to receptionist to be photocopied

Medical History

Approximate Weight of Patient: _____

Patient's Name _____ Birthdate ____/____/____

Physician Name & Phone # _____

Reason for today's visit? _____

Work related injury? (circle) **YES** **NO** Have you been under the care of a physician? (circle) **YES** **NO**

Date of last dental visit _____ Have you ever been hospitalized? (circle) **YES** **NO**

Date of last dental x-rays _____ Ever had Novocain or other local anesthetic? (circle) **YES** **NO**

If wearing dentures, age of dentures: _____

Are you taking or have taken any steroid/cortisone therapy in the last 2 years? (circle) **YES** **NO**

Are you taking or have taken Oral Bisphosphonates, eg, **FOSAMAX, ACTONEL, BONIVA,** or IV Bisphosphonates, eg, **ZOMETA, AREDIA?** (circle) **YES** **NO** Taken for how long?

Are you currently taking or prescribed **Suboxone**, **Vivitrol**, or **any other medications** used to treat addiction? (circle) **YES** **NO**

Have you had any adverse reaction or become ill to penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? (circle) **YES** **NO**

List any medications you are allergic to -

_____

List any medications you are taking including non-prescription drugs including herbals/vitamins -

_____

Do you have a history of:	**Y**	**N**		**Y**	**N**		**Y**	**N**		**Y**	**N**
Alcoholism			Epilepsy or Seizures			Pain In Jaw (TMJ)			Use of Tobacco		
Allergies			Excessive Bleeding			Pregnancy Complications			Venereal Disease		
Anemia			Fainting Dizzy Spell			Psychiatric Disorders			Other:		
Arthritis			Heart Problem			Radiation Treatment					
Artificial Joints			Hepatitis			Respiratory Problems					
Aspirin/ Anticoagulant			High Blood Pressure			Rheumatic Fever					
Asthma			HIV			Rheumatism					
Blood Transfusions			Implants (any)			Sinus Problems					
Breathing Problems			Kidney Disease			Stroke					
Cancer			Liver Disease			Teeth Grinding/Clench					
Chemotherapy			Low Blood Pressure			Thyroid Disease					
Diabetes			Mitral Valve Prolapse			Transplants					
Dialysis			Mouth Sores/Growths			Tuberculosis					
Drug Addiction			Pacemaker Heart Surgery			Ulcers Stomach Probs					

Women		**Y**	**N**		**Y**	**N**
Is there a possibility of pregnancy?				Are you nursing?		
Estimated Delivery Date	____/____/____			Are you taking any birth control prescriptions?		

Note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Please consult your physician/gynecologist for assistance regarding additional methods of birth control.

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

Patient's Signature _____ Date _____ Dr's. Signature/Medical History Review _____ Date _____

If a legal guardian is signing, please indicate relationship: _____

Treatment Plan Estimates

We typically prepare a Treatment Plan Estimate so that patients can understand the estimated costs of their recommended treatment prior to its start. The Treatment Plan Estimate is a good-faith attempt to predict the cost of your treatment based on the facts known to us when the estimate is made. As your treatment progresses, your dentist may determine in consultation with you that different or additional treatment is necessary and your financial responsibility may change. There may be times where we need to add additional treatments due to uncertainty of the treatment progress (i.e. when a simple extraction turns into a surgical one or when it is determined that you needed a buildup or post to support the crown that we intended to create).

If you have dental insurance, 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 of insurance benefits is based on information provided by your insurance company and by you. In all cases, you are responsible for amounts not covered by your insurance, unless prohibited by law or contractual agreement. In all cases, we encourage all patients with insurance to refer to their member handbooks or to call their plan administrators with any questions or concerns relating to specific benefits. Remember, any information obtain from your insurance are merely guidelines. It does not mean coverage is guaranteed.

In the event your insurance company(s) do not pay as much as we estimated, you will be responsible for the balance. In the event there is a limitation in benefits or if you were determined to be ineligible or not covered for your treatment, you will be responsible for the balance.

Predetermination of Insurance Benefits

If you have insurance benefits, you may have the option to seek a Predetermination of Benefits before you proceed with any treatment.

Predetermination of Benefits is a process whereby your insurance company or plan administrator tells you in advance of treatment what procedures may be covered by your insurance plan, the amount the insurance company may pay toward those procedures, and the amount you may be required to pay. Requesting a Predetermination is similar to submitting a claim before the dental procedure or service has taken place.

Because the Predetermination comes directly from your insurer or plan administrator, the risk of error as to your coverage is reduced. If your treatment includes extensive or complex services, such as bridges, crowns, dentures, or periodontal work, a Predetermination may be particularly helpful to allow you to appropriately budget for the services or discuss any potential alternative treatment that may be available if necessary.

The Predetermination of Benefits process gives you useful information about what services may be covered. However, your insurer will inform you that a Predetermination of Benefits is not a guarantee of coverage. A Predetermination sets forth your expected benefits based on the information available to the insurer at the time the Predetermination is prepared. The Predetermination may not consider, for example, a prior claim submitted by another dentist for services provided to you, changes in your coverage that occur after the Predetermination is made but before the services actually are provided, or the insurance company's subsequent opinion that a condition could have been treated by a less costly alternative to the service provided by our dentist.

The time it takes to receive a Predetermination from your insurance company or plan administrator can vary from as few as two weeks to as many as eight weeks. The decision to seek a Predetermination of Benefits or to proceed with treatment immediately is your own, unless your plan required otherwise. Please inform the Office Manager if you would like to request a Predetermination of Benefits from your insurer.

Patient's Signature Date

Signature of Parent/Guardian/Legal Representative Date

Payment Policy

Payment Policy

In all cases, our patients agree to the following payment policies. Payment in full of the estimated patient portion of the fees is due at the time services are provided.

For comprehensive treatment plans requiring multiple office visits, we require a minimum deposit of 70% of the total estimated patient portion of the fees at the start of treatment. For single visit appointments, we require payment before treatment.

Patients are always responsible for amounts not covered by insurance, regardless of whether the original estimate included an expected insurance benefit, unless prohibited by law, or unless we have a contractual agreement with any plan prohibiting all or a portion of such changes.

As set forth below in the Refund Policy, any portion of your deposit for services not rendered will be refunded if you choose not to proceed with your full comprehensive treatment plan. However, any deposits or payment towards a scheduled treatment can be subject to forfeiture if you do not give us at least 72 hours in advance notice to modify the appointment.

Refund Policy

You may discontinue treatment and ask for a refund from us at any time for the portion that was not used. Alpha Dental will refund any amount paid for treatment that you did not receive except when it comes to our policy for Interrupted Denture/Partials/Crowns Services, set forth below, applies. If you started a multi-step procedure and fail to finish the treatment, the amount you have paid towards it is not able to be refunded. If you interrupt a procedure by not coming back for the follow-up/subsequent visits within a reasonable amount of time (typically within at least 3 weeks), and the treatment we are rendering no longer fits, a refund will not be issued (i.e. waited too long between denture/partials steps and they no longer fit, or if your crown/bridge was ready to be seated and you either broke off the tooth beyond repair or waited too long to seat them and it no longer fits).

Refunds will be mailed or transmitted within fifteen (15) business days of our receipt of your request. If you have paid for services not yet provided and do not return to our office for six (6) months, we will send you a written notice offering a prompt refund of your balance. Refunds will be made in the same manner as the original payment, except that cash and money order payments will be refunded by check.

All requests for refunds should be submitted with a contact us request on our website alphadental.net or sent directly to:

Alpha Dental
Attn: Refund Processing
4770 W. Broad St.,
Columbus, OH 43228

Patients With Insurance

Alpha Dental's Payment Policy, stated above, applies to all patients, including those with insurance, subject to the following:

A) In Network

If we are a participating provider in your plan network, your insurer may impose on us requirements that can impact your obligation to pay. For example, we may be required to receive approval from you in advance of treatment for non-covered services or may charge you only your co-payment at the time covered services are provided. In all cases, we will bill you pursuant to the terms of its agreement with your insurer or plan.

B) Out of Network

Even if we are not a participating or in-network provider with your insurance plan, we may still work with your plan on an out-of-network basis if you assign benefits to be paid to us. We will reduce your payment or deposit of your estimated insurance benefit, but you must assign the benefits to be paid for dental services to us. If the insurance plan will not pay benefits directly to us, you will bear full financial responsibility for your treatment plan, according to our payment policy.

Payment Policy

C) Insurance Discounts

Insurance companies often negotiate discounts with us for services provided to their plan members. Depending on the procedure, we can charge additional services at the discount rate even after the insurance benefit has been exhausted when the agreement between your insurer and us requires so.

D) Interrupted Denture/Partials/Crowns/Bridges or Multi-Step Service Charges

Patients requiring multi-step visits may cancel their treatment at any time during the fabrication process prior to the completion of your prosthetic. If you choose to cancel prior to completion, you will be charged $500 per visit for each step in the fabrication process, not to exceed $2,500, depending on how many steps have been completed. Once your prosthetic is fabricated, you are responsible for its full fee. Special prosthetics or multi-step procedures can be more.

E) Accepted Forms of Payment

We accepts cash, personal checks, Visa, MasterCard, American Express, Discover, assigned insurance benefits, and approved third-party financing.

F) Third-Party Financing

We offer treatment financing through third-party lenders, such as CareCredit. We typically pay these companies fees on a sliding scale for making loans available to its patients and for servicing these loans. As the aggregate amount of care financed through these lenders increases, the fees they charge us decrease. This sliding-scale pricing arrangement does not affect your loan amount or the cost of treatment. You must, however, make sure to make all your payments timely, otherwise be faced with default consequences.

Patient Satisfaction Contact Information

Alpha dental is committed to providing all patients with exceptional services and care. If you feel you have an issue, please call your local office and speak to the coordinator. We will respond to you as quickly as possible (always within two business days from our initial contact with us). We are committed to your total satisfaction and we look forward to resolving any issues quickly and courteously.

Notice of Privacy Practices (must be signed by all new patients)

By signing below, I acknowledge that I have read our Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Patient's Signature Date
(If patient is a minor or disabled, the Parent, Guardian, or Attorney-in-Fact must sign above)

Payment, Insurance, and Financial Arrangement Policies (must be signed by all new patients)

By signing below, I acknowledge that I have read, understood, and agree to all terms of the attached. I acknowledge that I have been informed of the treatment plan and estimated fees. I agree to be responsible for all charges for dental services not paid by my dental insurance plan, unless prohibited by law, or unless a contractual agreement with my plan prohibits all or a portion of such charges.

Patient's Signature Date
(If patient is a minor or disabled, the Parent, Guardian, or Attorney-in-Fact must sign above)

Notice of Privacy Practices

This notice describes how health information about you may be used, disclosed, and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information.; We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect immediately and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification licensing, or credentialing activities.

By signing this section, you give us the authorization to release your chart and xray records to other healthcare providers that requests it from us. Typically, this would include other doctor/dentist's offices you were referred to or that you elected to go to. The purpose of this authorization is to help the other doctor/dentist office to understand information regarding your oral health. These records include are STRICLY LIMITED TO: Xrays, Chart/Progress Notes, Health History, and Treatment History. We DO NOT release information regarding your ledger or insurance/payment history. (You can opt to not sign this part)

*X*_____ *Anything information you do NOT want us to release:* _____

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorizations while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written consent.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Notice of Privacy Practices

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, e-mails, post cards, or letters).

Patient Rights.

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page, $18.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure).

Discloser Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclose of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions and Complains

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or alternative locations, you may complain to use using the contact information listed at the end of this Notice. You may also submit a written complaintto the U.S. Department of Health and Human Services. We will provide you with the address to file your compliant with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Alpha Dental Telephone: 614-853-3232 Address: 4770 W. Broad St., Columbus, OH 43228

*****You may refuse to sign this acknowledgement*****

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

Printed 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 situation prevented us from obtaining acknowledgment

☐ Other (Please specify)