BRYN MAWR PERIODONTAL ASSOCIATES

-Confidential- ***ACQUAINTANCE FORM***

*Date*_____

GENERAL INFORMATION

☐Dr. ☐Mr. ☐Ms.
☐Mrs. ☐Miss_____ _____
Last First Middle **Birthdate**

Residence
Address_____ (___)_____
Number Street City Zip Telephone

Employer_____ Social Security #_____

Address_____ (___)_____
Number Street City Zip Telephone

Name of Spouse _____ Spouse Employed by_____

By whom were you referred?_____ Patient e-mail_____

Patient Cell _____

DENTAL HISTORY

General Dentist_____ (___)_____
Telephone

Address/Location_____

Other Dentists (Specialists, Etc.)_____ (___)_____
Telephone

Address/Location_____

Are you presently experiencing any **Dental** pain or swelling?_____ Date of last full mouth X-ray_____

What is your immediate **Dental** concern? _____

MEDICAL HISTORY

Family Physician _____ (___)_____
Telephone

Address/Location_____

Other Physicians (Specialists, etc.) _____ (___)_____
Telephone

Address/Location_____

Date of last complete medical examination_____

Do you have a current medical problem? _____

If yes, please explain: _____

Have you had any major operations? _____

Do you use tobacco?_____ How much?_____

Do you take aspirin?_____ How often? _____

Are you allergic to any medications?_____

Are you taking any medication? Please list:

Taking _____ For_____ Taking_____ For_____

Taking _____ For_____ Taking_____ For_____

Taking _____ For_____ Taking_____ For_____

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Heart trouble/murmur	☐	☐	Diabetes	☐	☐	Nervous Disorders	☐	☐	Cancer
☐	☐	Rheumatic Fever	☐	☐	Stroke	☐	☐	Asthma/Hayfever	☐	☐	Arthritis
☐	☐	High/low blood pressure	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐	Alcohol
☐	☐	Chest pains/shortness of breath	☐	☐	Dizziness/Fainting	☐	☐	Infectious Hepatitis	☐	☐	Bulimia/Anorexia
☐	☐	Swollen ankles	☐	☐	Headaches	☐	☐	HIV	☐	☐	Drugs

Head and neck exam:
•Tongue •Nodes
•Throat •Skin

Patient's Signature _____

DDS/DMD _____

(over)

INSURANCE INFORMATION

If you have any type of DENTAL insurance, please complete the following

I. Name of Primary Insurance Carrier _____ Group Number: _____

Employee _____ _____ (Birthdate) Employee Social Security # / I.D. # _____

Patient _____ _____ (Birthdate) Relationship to Employee _____

Employer _____ (____) _____ (Telephone)

Address _____

II. Name of Secondary Insurance Carrier _____ Group Number: _____

Employee _____ _____ (Birthdate) Employee Social Security # / I.D. # _____

Employer _____ (____) _____ (Telephone)

Address _____

III. Does the patient have MEDICAL insurance? Yes_____ No_____

Primary Medical Insurance Co. _____ Group # _____ ID # _____

Secondary Medical Insurance Co. _____ Group # _____ ID # _____

DENTAL OFFICE INFORMED CONSENT

It is very important to us that you, our patient, understand that the dental treatments and procedures are not to be taken for granted as being routine or without risk of complications. As with all medical treatment to one's body, including dental treatment, there are no guarantees that the results will be as planned and to each individual's satisfaction. When dealing with the human body, there are potentially many variables, some predictable and others not. Complications rates in dentistry are low but they do exist. Even minor procedure such as "filling" can lead to major complication that can't be foreseen. For example, a "Novocain" injection could lead to allergic reaction, anaphylaxis, facial hemorrhage, swelling, bruising, and even hospitalization or death. Granted these are fairly uncommon occurrences but individuals who are contemplating this should be aware of this prior to consenting. These complications can be transient or may persist requiring further treatments.

The above examples are only samples of possible complications with dental treatment and are not limited to these. In general, complications include but are not limited to pain, swelling, bleeding, infection, fractures and other nerve problems.

I have read, understand and consent to dental treatments.

TELEPHONE CONSUMER PROTECTION ACT (TCPA):

You agree, in order for us to service your account or to collect monies you may owe, American Dental Group PC or American Dental Specialties PC, and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using prerecorded/ artificial voice messages and/or use of automatic dialing device, as applicable. I/We have read this disclosure and agree that American Dental Group PC or American Dental Specialties PC, its employees and/or agents may contact me/us as described above.

FINANCIAL POLICY

1. PATIENTS WITH INSURANCE COVERAGE:

Please understand that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will be glad to help you obtain the appropriate benefits from your insurance carrier as a courtesy to you, but ultimately it is patient's responsibility to understand their insurance benefits. Routine treatments are generally performed without submitting a request of pre-estimate of benefits. Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due prior to the treatment. If your insurance company denies the claim, the balance will be automatically transferred to you. In some cases, insurance carrier may pay for alternative benefits than the treatment performed. In this case you are responsible to pay for the difference. **All procedure involving lab work will require 50% down payment, then the remaining 50% balance will be due at the day of final insertion.**

2. PATIENTS WITHOUT INSURANCE COVERAGE:

Patients without insurance coverage are required to pay for services as rendered. We accept Cash, Check, MasterCard, Visa, Discover, American Express or Debit/ATM cards. We also offer patient financing plans.

3. ALL PATIENTS:

a. Unless other arrangements have been made in advance, all copay and deductibles **must be paid** at the time of service. You may have to pay approximate payment towards the co-payment for the dental treatments. We may keep the credit balance, if any, towards your future treatment. It is your responsibility to request our office for a statement of accounts or a refund of your credit balance.

b. Checks returned unpaid from the bank, or credit card chargebacks are subject to $30.00 service fee.

d. Accounts delinquent more than 30 days from the date of billing are subject to a 1.5% per month (18% annually) finance charge. If your account is sent to our collection agency, you will be responsible for collection and court costs along with attorney's fees. Accounts referred to an outside collection agency may be subject to a collection fee of 25%, which will be added to the total balance due at the time of write-off.

Office Policy Concerning Scheduling Appointments

When you make an appointment, we reserve that time for you. We understand that extreme or unavoidable emergencies or circumstances do arise which may require you to cancel your appointment. We reserve the right to charge for any appointment(s) broken without 24 hours advance notice. The charge will be $100.00 for every thirty minutes of appointment time reserved.

We welcome you to our office and want to provide you service with the best possible care. If you have any questions regarding our policies and your treatment, please do not hesitate to ask.

I HAVE READ AND UNDERSTAND THE ABOVE DENTAL OFFICE INFORMED CONSENT, FINANCIAL POLICIES AND OFFICE POLICY CONCERNING SCHEDULING APPOINTEMTS. I HAVE RECEIVED A COPY OF OFFICE'S NOTICE OF PRIVACY PRACTICES.

X_____ _____

Signature of Patient/Parent/Guardian **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 acknowledgement ☐ Other (Please Specify)

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Bryn Mawr Periodontal Associates

SECTION A: PATIENT GIVING CONSENT

Full Name (Please Print): _____

Home Address: _____

Home Telephone: _____

Cell Phone: _____ Social Security Number: _____

Office Telephone: _____ E-mail Address: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENT CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, healthcare operations, and to work with your insurance carrier.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature and Acknowledgement of Receipt of Notice of Privacy Practices: I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. I give permission for this office to leave messages on any personal home phone, cell phone, or e-mail.

*Signature*_____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____