SHWARTS FAMILY DENTISTRY

Patient Information

Patient Name: _____ Preferred Name: _____ Date: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐Child ☐ Other _____

Birth Date: _____ Email: _____ Spouse: _____

Phone: _____ _____ _____
Cell Home Work

Address: _____
Street Apt. City State Zip Code

Mailing Address (if different): _____

SSN: _____ Employer Name: _____ Occupation: _____

How did you hear about us? _____ Previous Dentist: _____

Billing, Credit, and Insurance Information

☐ I am not covered by dental insurance

Insurance Information:

Name of Insured: _____ Insured Birth Date: _____ Insured SSN: _____

Insured's Employer Name: _____ Insurance Name: _____

Group #: _____ Insured ID #: _____ Insurance Phone:_____

Insurance Address: _____

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Medical History

Primary Physician: _____ Phone: _____

Have you ever had surgery? Yes No
If yes, when and what for? Date of surgery:_____ Reason for surgery:_____
Date of surgery:_____ Reason for surgery:_____
Do you have any allergies? (Latex, penicillin, etc.) If so, please list: _____

PATIENT MEDICAL HISTORY

Do you have or have you ever had:

Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)?	Yes	No	Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	Yes	No
Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	Yes	No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes	No
Kidney disease or kidney failure, requiring dialysis?	Yes	No	Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
Thyroid disease?	Yes	No	Arthritis?	Yes	No
Stomach ulcers or colitis?	Yes	No	Significant weight loss or gain?	Yes	No
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Frequent or recurring mouth sores?	Yes	No	Sinus or nasal problems?	Yes	No
Glaucoma?	Yes	No	Sleep apnea?	Yes	No
Diabetes?	Yes	No	Osteoporosis or osteopenia?	Yes	No

Any cancer, radiation, or chemotherapy? Yes No
Describe: _____Date of your last treatment? _____

Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Yes No

If yes, please explain: _____

Do you need to be pre-medicated with antibiotics prior to dental treatment? _____

Are you pregnant? _____ Due date: _____ OB/GYN: _____

Are you currently taking any medications (prescriptions or over the counter)? Please list: _____

_____

Do you smoke? (if so, how much?) _____ Drink? (if so, how many drinks per week?) _____

Have you ever had complications following dental treatments? (If yes, please explain) _____

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I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible. To the best of my knowledge, the above information is complete and correct.

SIGNATURE: _____ DATE: _____

Office Policies

- Financial arrangements must be made in advance. Financial responsibility on the part of each patient must be determined before treatment, including any insurance benefits. Payment is due at the time of service. We accept Visa, Master Card, Discover, American Express, Personal Checks or Cash. Payment arrangements can also be made through Care Credit. Payment in full at the date of service is eligible for a 10% discount. Any dental services performed without previous financial agreements, must be paid at the time services are rendered. If you have any questions concerning this payment method, please speak with Beverly our payment expert.

- If you are unable to make your dental appointment, we ask you call our office at least 24 hours prior to your dental appointment to make other time arrangements or reschedule. A $50 charge will be added to your account if notice is not received timely. If consistent cancellations without prior notice occur you may be asked to pay for your visit in advance to reserve your appointment again.

  We understand how important and busy schedules can get and want to be respectful of your time; therefore we ask that you arrive promptly in order for us to provide the same timely courtesy to other patients as well. By signing below, I acknowledge that I am aware and agree to follow the office policy.

Signature _____ Date _____

SHWARTS FAMILY DENTISTRY

Your Dental Insurance

We will help prepare the patient's insurance forms, assist in making collections from insurance companies and will credit any collections to the patient's accounts. The "Patient Portion" on our treatment plan is only an estimate of what your insurance may pay. However Dr. Ellis Shwarts does not render services based on the assumption that our charges will be paid in full by insurance companies. In the event your insurance company pays less than their estimated amount, *you are responsible for the unpaid portion and will be billed.*

- *Although insurance is your responsibility… we can help. Regardless of what we might calculate as your benefit in dollars, we must stress the fact that you are responsible for the total cost of your dental care. As a courtesy to you, we will file your insurance to get the maximum amount due you under your plan's provision. You should contact your employer or union to obtain precise information regarding your benefits.*

- *Many plans tell their insured that they will be covered "up to 80%" or up to "100%," but do not clearly specify limitations. We have found that most plans covered about 35% or 65% of major services based on the plan's pre-established maximum fee allowances and caries from carrier to carrier.*

- *You may receive a letter from your insurance company stating that dentals fees are higher than usual and customary, rather than saying their benefits are low. An insurance company surveys a geographic are, finds the average fee and then takes 90% of that fee and considers it customary.*

- *Many routine dental services are not covered by insurance carriers.*

In the interest of your good health and the aesthetics of your dental work, Dr. Ellis Shwarts uses composite (tooth colored) fillings and porcelain (tooth colored) crowns on all teeth, unless alternate treatment is needed. You are being informed that most, but not all, insurance companies only allow the benefit of amalgam (metal fillings) and metal crowns on posterior (back) teeth. You will be responsible for the amount that your insurance does not cover.
This will allow us to maintain standard of care and deliver the best treatment to our patients.

I have read the above conditions of treatment and payment, and I understand and agree.

Signature (parent if minor) _____

Date _____

Relationship to patient _____

SHWARTS FAMILY DENTISTRY

Authorization and Consent

To Send Unencrypted Patient Information by Email and Other Electronic Means

Until I tell you in writing to stop, I authorize Shwarts Family Dentistry to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or Shwarts Family Dentistry health care operations. The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment, and payment records.

I understand that:

- I do not have to sign this form.
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I don't sign this form, Shwarts Family Dentistry may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be redisclosed and no longer protected by privacy law.
- Shwarts Family Dentistry does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that Shwarts Family Dentistry already sent before receiving my written instructions to stop.

Patient name (please print) _____

Signature (parent signature if minor): _____ Date: _____

SHWARTS FAMILY DENTISTRY

Notice of Privacy Practices

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. My signature below is acknowledgement that I have reviewed the Notice of Privacy Practices for the office of Shwarts Family Dentistry and am in agreement.

Patient name _____ Date _____

Signature (parent if minor) _____ Date _____

Witness _____ Date _____

Release of Information

□ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

_____

_____

□ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

The following numbers may be used to contact me

□ my home _____
□ my work _____
□ my cell _____
□ other _____

If unable to reach me: □ you may leave a detailed message □ please leave a message asking me to return your call

□ _____

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: ____/____/_____