INSURANCE AND FINANCIAL POLICY

Thank you for choosing Vancouver Dental for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need.

- **Payment for services is required at the time service is provided**. Accepted forms of payment include Cash, Checks, Visa, MasterCard, American Express, Discover and Care Credit.

- **Insurance patients:** Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.

- We currently accept most insurance plans. This means that we work with **literally hundreds of companies**. Although we maintain computerized histories of payment by a given company, **they do change**; therefore it is **NOT possible** to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. Insurance companies do not provide us with accurate charges for any procedures.

- We bill your insurance company as a courtesy to you. If your insurance does not pay within 60 days, **Vancouver Dental** reserves the right to request payment from you, in full, for services provided and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between **YOU** and **your insurance company**. Our office is not, and cannot be a part of that legal contract. **Ultimately, you are responsible for all charges incurred in our office.**

- **Patients without insurance:** Payment is required **in full at the time of service**. We understand that without dental insurance it can be difficult especially if there are extensive dental needs. Please consult with our treatment coordinator for payment options including 3rd party financing options such as Care Credit.

- **Minor Patients:** The adult accompanying a minor and the parents (or guardians) are responsible for **full payment,** regardless of court child support order. For unaccompanied minors, non-emergency treatment will not be done unless prior approval and financial arrangements have been made.

- **Emergency Visits:** In the event of an **emergency** after regular business hours a $55 emergency fee will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged $125 for an after hours emergency fee.

- **Financial Arrangements:** I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of my account owed on this or subsequent visits, I agree to pay for all costs and expenses, including reasonable attorney fees. Any returned check will be assessed a $35 fee no further checks will be accepted from that patient. If the account should be turned over to a collection agency, for any reason, 10% of the principle balance will be added for interest along with an additional 10% service charge.

I have read the insurance and financial policy above. I understand and agree to abide by the listed terms.

_____ _____

Signature of Financially Responsible Party Date

PATIENT REGISTRATION & HEALTH HISTORY FORM

Date: _____

PATIENT INFORMATION

First Name: _____ M: _____

Last Name: _____

Preferred Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____

Gender: _____ Is the patient a minor? Yes ☐

Relationship Status: Single ☐ Partnered ☐ Married ☐ Divorced ☐ Widowed ☐

Is the patient a student? Full Time ☐ Part Time ☐

Employer: _____

Phone: _____

Occupation: _____

Employer Address: _____

_____

Spouse's Name: _____

Date of Birth: _____

How did you hear about us?: _____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to patient: _____

Insurance Co: _____

Group #: _____

Subscriber ID/SSN: _____

Is patient covered by additional insurance? Yes ☐ No ☐

Subscriber's Name: _____

Date of Birth: _____

Relationship to patient: _____

Insurance Co: _____

Group #: _____

Subscriber ID/SSN: _____

ASSIGNMENT AND RELEASE. I certify that I, and/or my dependents have insurance coverage with _____ and assign directly to Vancouver Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above name dental practice may use my health care information and may disclose such information to the above named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

CONTACT INFORMATION *REQUIRED INFORMATION*

*Cell Phone(_____)_____ Is it okay to send text messages for appointment confirmations and reminders? Yes ☐ No ☐

*Email Address: _____ This is used for appointment reminders/confirmations. This is never used for spam or given out to anyone else.

Home Phone(_____)_____ Work Phone(_____)_____ Best time and place to reach you: _____

Emergency Contact: Name _____ Relationship _____ Phone (_____) _____

DENTAL HISTORY

Reason for today's visit: _____

_____

Date of last dental visit: _____

Date of last dental X-rays: _____

	Yes	No
Do you have bleeding gums?	☐	☐
Do you use any form of tobacco?	☐	☐
Do you have dry mouth?	☐	☐
Does food collect between your teeth?	☐	☐
Do you grind your teeth?	☐	☐
Any loose teeth or fillings?	☐	☐
Do you have any jaw pain?	☐	☐

SMILE EVALUATION

	Yes	No
Would you like your teeth to be straighter?	☐	☐
Would you like your teeth to be whiter?	☐	☐
Have you noticed any wear or chipping of your teeth?	☐	☐

If there is anything you could change about your teeth, what would it be?

_____

SLEEP HEALTH

	Yes	No
Do you snore?	☐	☐
Do you wakeup not feeling refreshed?	☐	☐
Do you wakeup in the morning with headaches?	☐	☐
Is it hard to stay awake during the day?	☐	☐

HEALTH HISTORY

Yes	No		Yes	No		Yes	No	
☐	☐	AIDS/HIV	☐	☐	Herpes	☐	☐	Artificial Heart Valves
☐	☐	Anemia	☐	☐	High Blood Pressure	☐	☐	Artificial Joints
☐	☐	Anxiety	☐	☐	Jaundice	☐	☐	Abnormal Bleeding After Surgery
☐	☐	Arthritis, Rheumatism	☐	☐	Kidney Disease	☐	☐	Congenital Heart Lesions
☐	☐	Asthma	☐	☐	Liver Disease	☐	☐	Heart Murmur
☐	☐	Back Problems	☐	☐	Low Blood Pressure	☐	☐	Mitral Valve Prolapse
☐	☐	Blood Disease	☐	☐	Nervous System Problem s	☐	☐	Pacemaker
☐	☐	Cancer	☐	☐	Psychiatric Care	☐	☐	Rheumatic Fever
☐	☐	Chemical Dependency	☐	☐	Radiation Treatment	☐	☐	Scarlet Fever
☐	☐	Chemotherapy	☐	☐	Respiratory Diseas e	☐	☐	Stroke
☐	☐	Circulatory Problems	☐	☐	Shortness of Breath	☐	☐	Premedication needed for dental visits?
☐	☐	Cortisone Treatments	☐	☐	Sinus Trouble	☐	☐	Are You Pregnant?
☐	☐	Diabetes	☐	☐	Swollen Neck Glands			
☐	☐	Emphysema	☐	☐	Thyroid Problems			
☐	☐	Epilepsy	☐	☐	Tonsillitis			
☐	☐	Fainting or dizzines s	☐	☐	Tuberculosis			
☐	☐	Glaucoma	☐	☐	Tumor or growths on head			
☐	☐	Headaches	☐	☐	Ulcer			
☐	☐	Hepatitis Type _____						

Other Heart Problems: _____

_____

_____

Other Medical Conditions: _____

_____

_____

MEDICATIONS

Please list any medications that you are currently taking:

_____

_____

_____

_____

_____

Physician Name: _____

Physician Location: _____

Physician Phone: _____

ALLERGIES

	Yes	No
Penicillin or other antibiotics	☐	☐
Aspirin	☐	☐
Codeine or other narcotics Iodine	☐	☐
Latex	☐	☐
Local Anesthetic	☐	☐
Sulfa Drugs	☐	☐
Reaction to metals	☐	☐

Other/Details: _____

The undersigned hereby authorizes the doctors and staff at Vancouver Dental to perform dental exams, take x-rays, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize the doctors at Vancouver Dental to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize the use of anesthetics and understand that use of anesthetics embodies a certain risk.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Sign here: _____ Date: _____

Doctor: _____ Date: _____

LATE AND MISSED APPOINTMENT POLICY

At Vancouver Dental, our goal is to provide quality dental care. To do this it requires a time commitment from you as well as from us. When you reserve an appointment, you will have our time and attention as well as materials and equipment setup just for you.

If for any reason your appointment must change, it is important that you give our office **at least 48 hours notice** to avoid a $25 rescheduling fee.

I have read the policy above. I understand and agree to abide by the listed terms.

_____ _____

Signature of Financially Responsible Party Date

VANCOUVER DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may Refuse to Sign This Acknowledgement

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, as required by law, 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): _____

_____

_____