WELCOME TO CAPSTONE DENTAL CARE

We are pleased to welcome you to our practice. Please take a few minutes to complete this form. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health. If you have questions about your suggested treatment plan or the available payment options, please ask us. We are here to help you!

Patient Information:

Last Name: _____ First: _____ Middle Initial: _____ Preferred:_____

Sex: o Male o Female Marital Status: o Married o Single o Divorced o Separated o Widowed

Birthdate:_____ Age:_____ Soc Sec:_____ DL#:_____

Address:(1) _____ (2)_____

City: _____ State:_____Zip: _____

Home Phone: _____ Work Phone: _____Ext: _____ Cellular: _____

Email: _____ o I would like to receive correspondence via email

***In case of emergency, please contact:**_____ **ph:**_____

Responsible Party (if someone other than patient):

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City: _____ State/Zip: _____

Home Phone: _____Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____Social Sec: _____ Drivers Lic: _____

Primary Insurance Information:

Name of Insured: _____

Insured Soc. Sec: _____

Insured Birth Date: _____

Contract ID#:_____

Policy Holder Employer_____

Secondary Insurance Information:

Name of Insured: _____

Insured Soc. Sec: _____

Insured Birth Date: _____

Contract ID#:_____

Policy Holder Employer_____

HOW DID YOU HEAR ABOUT OUR OFFICE?

_____

- Payment of your portion at each visit (circle one)

We accept:

Cash Check Visa MasterCard American Express Discover

_____/_____

Card # Exp. Date

- Care Credit Payment Plan

*subject to credit approval. See patient brochure for information.

I hereby authorize payment directly to Capstone Dental Care of insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dentists of Capstone Dental Care to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/ medical histories are correct to the best of my knowledge. I grant the right to Capstone Dental Care to release my dental/medical histories and other information about my dental treatment to third party payers and/ or other health professionals.

INTIAL_____

While Dr. John C. Bennett and Dr. Jennifer T. Dickson are in-network providers for several insurance companies, Capstone Dental Care will file on any and all dental insurance plans. It is the responsibility of the patient to confirm that you are covered on your service date. Our office will file your insurance claims with most dental insurance carriers to assist you in receiving your benefits. However, we can make no guarantee of any estimated coverage because an insurance policy is an agreement between you and your insurance company. All patients are directly responsible for all charges. **CO-PAYMENT and/or YOUR ESTIMATED PORTION OF ANY CHARGE IS DUE ON THE SAME DAY OF SERVICE**. Postdated checks are no longer accepted. If for any reason your insurance has not paid your claim within 60 days from the date of service, you are responsible for full payment. If not paid, a **service charge** will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month, which is an annual percentage rate of 18% applied to the last month's balance. In the case of default payment, the party responsible promises to pay any legal interest on the balance due, together with any collection costs incurred, to effect collection of this amount for future outstanding accounts. **THERE WILL BE A $30.00 CHARGE FOR ALL RETURNED CHECKS.**

INITIAL_____

_____ _____

Signature of Patient/ Responsible Party Date Signed

APPOINTMENT CANCELLATION POLICY

We ask that you give a **24-hour notice** if you need to cancel or change your appointment. A $75.00 charge will be added to your account if an appointment is cancelled without proper notification.

INITIAL_____

MEDICAL HISTORY

Do you use tobacco? O Yes O No

Are you on a special diet? O Yes O No

Are you under a physician's care now? O Yes O No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? O Yes O No If yes, please explain: _____

Have you ever had a serious head or neck injury? O Yes O No If yes, please explain: _____

Do you use controlled substances? O Yes O No If yes, please specify: _____

Are you taking any medications, pills, drugs, vitamins or supplements? O Yes O No If yes, please explain:

_____

Women:

O Pregnant O Trying to get pregnant O Nursing

O Taking oral contraception

Are you allergic to any of the following?

O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics

O Other If yes, please explain: _____

Do you have, or have you had, any of the following?

O AIDS/ HIV Positive	O Cold Sores/Fever Blisters	O Frequent Headaches	O Kidney Problems	O Rheumatism
O Alzheimer's disease	O Congenital Heart Disorder	O Genital Herpes	O Leukemia	O Scarlet Fever
O Anaphylaxis	O Convulsions	O Glaucoma	O Liver Disease	O Shingles
O Anemia	O Cortisone Medicine	O Hay Fever	O Low Blood Pressure	O Sickle Cell Disease
O Angina	O Diabetes	O Heart Attack/ Failure	O Lung Disease	O Sinus Trouble
O Arthritis/ Gout	O Dizziness	O Heart Murmur	O Mental Disorder	O Spina Bifida
O Artificial Heart Valve	O Drug Addiction	O Heart Pace Maker	O Mitral Valve Prolapse	O Stomach/ Intestinal Disease
O Artificial Joint	O Easily Winded	O Heart Trouble/ Disease	O Nervous Disorder	O Stroke
O Asthma	O Eating Disorder	O Hemophilia	O Pain in Jaw Joints	O Swelling of Limbs
O Blood Disease	O Emphysema	O Hepatitis	O Parathyroid Disease	O Thyroid Disease
O Blood Transfusion	O Epilepsy or Seizures	O Hepatitis B or C	O Psychiatric Care	O Tonsillitis
O Breathing Problem	O Excessive Bleeding	O Herpes	O Radiation Treatments	O Tuberculosis
O Bruise Easily	O Excessive Thirst	O High Blood Pressure	O Recent Weight Loss	O Tumors or Growths
O Cancer	O Fainting Spells	O Hives or Rash	O Renal Dialysis	O Ulcers
O Chemotherapy	O Frequent Cough	O Hypoglycemia	O Respiratory Problems	O Venereal Disease
O Chest Pains	O Frequent Diarrhea	O Irregular Heartbeat	O Rheumatic Fever	O Yellow Jaundice

Have you ever had any serious illness not listed above? O Yes O No If yes, please explain:

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN: _____ **DATE:**_____

TELEPHONE CONSUMER PROTECTION ACT

You agree, in order for us to service your account or to collect monies you may owe CAPSTONE DENTAL CARE and/ or 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 pre-recorded/ artificial voice messages and/ or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that CAPSTONE DENTAL CARE, its employees and/or agents may contact me/us as described above.

- Request Appointments Online
- Confirm Appointments via Email
- Receive Text Message Appointment Reminders
- Submit Patient Satisfaction Surveys
- Refer Your Friends Online

_____ _____

Responsible Party Signature **Date Signed**

HIPAA ACKNOWLEDGEMENT

I have received a copy of this office's Notice of Privacy Practices and 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 health care operations as set out in the Notice. *Purpose of Consent By signing this form, you will consent to use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations as set out in the attached "Notice of Privacy" and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent. *Right to Revoke You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed in our Notice of Privacy Practices. 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 if you revoke this consent. 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 health care operations as set out in notice.

_____ _____

(Patient Signature) **Date Signed**

***If signed by a parent, guardian, or personal representative on behalf of the patient, complete the following**

_____ _____ _____

Parent, Guardian, or Representative Name **Relationship to Patient** **Date Signed**