AVENUES
Family Dentistry

FINANCIAL POLICY *and* AGREEMENT

Policy

Thank you for choosing Avenues Family Dentistry as your dental health care provider. We are committed to providing you with the highest quality dental care. The following is a statement of our financial policy which we require you to read, agree to and sign prior to any treatment. We thank you for the opportunity to serve you and welcome any question you may have concerning our financial policies.

- Payment for services is considered a part of your treatment and is due prior to treatment
- For co-pays of $250 or more, payment is due to secure the appointment time
- Forms of payment include: cash, personal check, MasterCard, Visa, Discover and American Express
- We offer third party financing options; approval is granted solely by the crediting company
- Returned checks are subject to additional fees, up to $50
- A **$50 fee** will be applied for appointments **cancelled/broken with less than 24-hour notice** _____ (initial here)
- Should it become necessary to enlist a collection service and/or legal assistance in collecting monies due to Avenues Family Dentistry, you will be responsible for any collection and/or legal charges

Dental Insurance Overview

I understand and agree that I am personally responsible for payment of all dental services, be it direct payment or issued through an insurance company. If you carry dental insurance, as a courtesy, we will assist you with processing your insurance claims; however all dental estimates are not a guarantee of payment and it is your responsibility to pay what your insurance does not pay.

Insurance payments are typically received 30-60 days from the time of filing and on rare occasions will take longer than expected. If your insurance company has not made payment within 45 days, we kindly ask that you contact your insurance company to obtain an expected payment date. We will cooperate fully with the regulations and the requests of your insurance company that may assist in claim payment. Our office will not, however, enter into a dispute with your insurance company over any claim.

Financial arrangements can be made with our Accounts Manager on the first visit. Our policy is to not carry a balance of an account for more than 3 months. Any account not paid after the grace period will be subject to an 18% interest rate annually from the original due date.

Agreement:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility of payment for dental services provided by Avenues Family Dentistry for myself or my dependents is my own, and/or attorney fees will be added to any overdue balance that requires collection initiatives.

I understand that in absence of prompt payment, my personal and financial records concerning these professional services will be released to Avenues Family Dentistry's legal representative(s) for collection. The legal representative will act as the providers "business associate" in compliance with federal HIPPA.

By signing below, I am authorizing Avenues Family Dentistry to call me at any number provided. I also agree to any fees or charges that may incur for incoming/outgoing calls, text messages, and emails to or from any such number, without reimbursement.

_____ _____

Patient's Printed Name Date

_____

Signature

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MEDICAL HISTORY FORM

Please check any of the following problems/conditions that apply to you:

- ☐ AIDS
- ☐ Allergies (seasonal)
- ☐ Anemia
- ☐ Angina (chest pain)
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bruise easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cortisone Medication
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart Condition
- ☐ Hepatitis A, B or C
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ HPV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervousness/Depression
- ☐ Pacemaker
- ☐ Pregnant (currently)
- ☐ Radiation (head/neck)
- ☐ Respiratory problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Sinus problems
- ☐ Sleep Apnea
- ☐ Stomach problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other:_____

Are you allergic or have you reacted adversely to any of the following medications?

- ☐ Aspirin
- ☐ Darvon
- ☐ Nitrous Oxide
- ☐ Percodan
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Tetracycline
- ☐ Codeine
- ☐ Erythromycin
- ☐ Valium
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other:_____

Have you ever taken any of the following medications?

- ☐ Actonel
- ☐ Aredia
- ☐ Fosamax
- ☐ Reclast
- ☐ Zometa
- ☐ Boniva
- ☐ Herbal Supplements
- ☐ Other:_____

Are you under a physician's care? If yes, for what reason?

_____

_____

_____

Please list current medications:

_____

_____

_____

Name of Physician: _____

Phone: _____

Do you currently smoke or use tobacco? Y or N

If so, for how long? _____

Dental History

How Long has it been since your last thorough dental exam?_____

Are you pleased with the appearance of your teeth?..... Y / N
Do you have swelling in or around your mouth, or sores that are slow to heal?..... Y / N
Does it hurt to open wide or do you experience clicking or other noise in your jaw joints?..... Y / N
Are your teeth sensitive to heat/cold or sweets?..... Y / N
Do you have problems with bleeding gums?..... Y / N
Do you have frequent bad breath or unpleasant taste in your mouth?..... Y / N
Do you have problems sitting in a dental chair?..... Y / N
Do you wear dentures or partials?..... Y / N
Do you feel you have had good dental care in the past?..... Y / N

Consent: I, the undersigned, hereby authorize Avenues Family Dentistry and its doctors and/or employees to take X-rays, study models, photographs and/or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs. I also authorize any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

_____
Patient's Printed Name

_____ _____
Signature *(Patient, legal guardian or authorized agent of patient)* Date

AVENUES Family Dentistry

Today's Date:

PATIENT REGISTRATION

Confidential Personal Information

Name ☐ M ☐ F Sex / / DOB Age

Street Address City State/Zip

☐ Single ☐ Married ☐ Separated ☐ Widowed Marital Status - - Social Security Number

( ) - Cell Phone ( ) - Home Phone Email

Employer ( ) - Work Phone ☐ Yes ☐ No Are you a full-time student?

/ / Mother's DOB (if patient is a minor) / / Father's DOB (if patient is a minor) Name of Spouse (or parent if patient is a minor)

( ) - Spouse's Cell Phone ( ) - Spouse's Work Phone Spouse's Email Spouse's Employer

Responsible Party

☐ Self ☐ Other Person responsible for account Name (if other than self) Relationship (if other than self) Driver's License Number

( ) - Cell Phone ( ) - Work Phone Email

Emergency Contact

Emergency Contact Name ( ) - Cell Phone Email

Other

How did you hear about our office?

☐ Mailer ☐ Web Search ☐ Social Media ☐ Drove By

☐ Referral from family/ friend ☐ Insurance Carrier ☐ Other

Dental Insurance

Primary Insurance	Secondary Insurance
Insured's Name & DOB:	Insured's Name & DOB:
Social Security #:	Social Security #:
Insurance Carrier:	Insurance Carrier:
Insurance Carrier's Phone#:	Insurance Carrier's Phone#:
Insured's Employer:	Insured's Employer:
Group #: ID#:	Group #: ID#:

☐ I do not have dental insurance