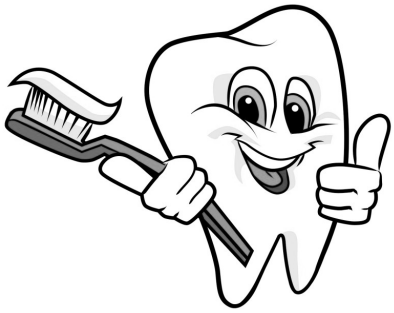
D.D.S.

Hitzel Dental

family • cosmetic • implant



Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help you.

Patient Information

(Please Print)

Name:_____Date:_____SS#_____
First Middle Initial Last

Sex: ❑Female ❑Male ❑Other Birthdate:_____E-mail:_____

Address:_____City:_____State:_____Zip:_____

Phone: (_____)_____ Work: (_____)_____ Alt. Phone: (_____)_____

❑Married ❑Widowed ❑Single ❑Minor ❑Separated ❑Divorced ❑Partnered for _____ years

Patient Employer/School:_____Occupation:_____

Spouse or Patient's name: _____ Phone:(_____)_____

Spouse or Patient's Employer:_____ Work Phone:(_____)_____

Whom may we thank for referring you to us? _____

Emergency Contact Name: _____ Phone:(_____)_____

Responsible Party

Name of person responsible for this account: _____

Relationship to Patient: _____ Phone:(_____)_____

Address:_____City:_____State:_____Zip:_____

Name of employer: _____ Work Phone:(_____)_____

Dental and Medical History

Hitzel D.D.S. Dental

Full name: _____ Preferred Name:_____ Age: _____

Employer: _____ Former Dentist: _____

Date of last dental exam:_____ Date of last dental X-rays: _____

How often do you brush?: _____ How often do you floss?:_____

Primary Physician: _____ Date of last visit: _____

Reason for today's visit: _____

Please list all medications you are currently taking: _____

_____

Allergies: _____

(Women) Are you pregnant? ❑Yes ❑No Nursing? ❑Yes ❑No Taking birth control? ❑Yes ❑No

Check (✓) if you have had any of the following:

❑ AIDS	❑Circulatory Problems	❑Hepatitis	❑Respiratory Disease
❑Anemia	❑Congenital Heart Lesions	❑Hernia Repair	❑Rheumatic Fever
❑Arthritis, Rheumatism	❑Cortisone Treatments	❑High Blood Pressure	❑Scarlet Fever
❑Artificial Heart Valves	❑Cough, Persistent	❑HIV Positive	❑Shortness of Breath
❑Artificial Joints	❑Diabetes	❑Jaw Pain	❑Skin Rash
Year placed:_____	❑Epilepsy	❑Kidney/Dialysis	❑Stroke
❑Asthma	❑Fainting	❑Liver disease	❑Swelling of feet or ankles
❑Back Problems	❑Glaucoma	❑Mitral Valve Prolapse	❑Thyroid Problems
❑Bleeding Abnormally	❑Headaches	❑Organ Transplant	❑Tobacco Habit
❑Blood Disease	❑Heart Murmur	❑Nervous Problems	❑Tonsillitis
❑Cancer	❑Heart Problems	❑Pacemaker	❑Tuberculosis
❑Chemical Dependency	Describe: _____	❑Psychiatric Care	❑Ulcer
❑Chemotherapy	❑Hemophilia	❑Radiation Treatment	❑Venereal Disease

Have you ever taken any of these medications?

Blood Thinners: ❑Coumadin ❑Warfarin ❑ Eliquis ❑ Paradaxa ❑Xarelto ❑Other: _____

Bisphosphonates: ❑Fosamax ❑Actone ❑Atelvia ❑Didrone ❑Bonvia ❑Other:_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have active insurance coverage at this time and assign directly to George E. Hitzel DDS PA 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.

George E. Hitzel DDS PA may use my healthcare information and may disclose such information to the above named insurance company(ies) 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 Date

_____ _____

Please Print name of Patient, Guardian, or Personal Representative Date

INSURANCE AND FINANCIAL POLICY

Hitzel D.D.S. Dental

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 contact your employer or insurance company directly.

INITIAL_____

We currently except many private care insurance plans. This means that we handle thousands of companies. Although we can maintain computerized histories of payments by a given company, they do change; therefore it is impossible to give you a guarantee quote at the time of service. We estimate your portion based on the most up-to-date information we have, but is ONLY AN ESTIMATE. If you would like to know your insurance benefit, we will be happy to file a "pre-determination authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage either. This does delay treatment but will give you the exact out-of-pocket figures you may require.

INITIAL_____

We will bill your insurance company as a courtesy. If insurance does not pay within 90 days, Hitzel Dental reserves the right to request payment in full for services from you 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 part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

INITIAL_____

Hitzel Dental does require payment in full for your estimated portion at time of service. We except MasterCard, Visa, Discover, cash, and checks (for existing and established patients with history). If you are in need of an extended finance option, we also work with Care Credit, in our office we offer 6 or 12 months "same as cash" with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit.

INITIAL_____

A specific amount of time is reserved especially for you and we strongly courage all patients to keep their appointments. If you must change your appointment we require AT LEAST 24 hours notice to avoid a $55.00/hour cancellation fee (emergencies are exceptions).

INITIAL_____

In the event of an emergency after regular business hours a $300.00/hour 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 $350.00/hour emergency fee.

INITIAL_____

_____

Signature of Patient, Parent, Guardian, or Personal Representative

_____ _____

Please Print name of Patient, Guardian, or Personal Representative Date

PATIENT CONSENT FORM

D.D.S.
Hitzel Dental

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the health insurance Portability and Accountability act of 1996 (HIPPA). I understand that by signing this consent that I authorize you to disclose my protected health information to carry out:

- treatment including direct or indirect treatment by other healthcare providers
- obtaining payment from third-party payers I eat my insurance company
- the day-to-day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and discloses of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out any treatment, payment, and my healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree to them, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclose that occurred prior to the date that I revoke this consent is not affected.

Release of Patient Information to: _____Relationship: _____

_____
Signature of Patient, Parent, Guardian, or Personal Representative

_____ _____
Please Print name of Patient, Guardian, or Personal Representative Date