Patient Information

Patient Name: ____ Date: __________
Last, First MI (Preferred Name)

Email ______________________________ Gender: __________ Family Status: ______________

Social Security #: __________________________ Birth Date: ____________________

Phone (Home): ____________ (Work): ____________ Ext: ______ Cell: ______________

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: ____
Street Apartment #

____
City State Zip Code

Emergency Contact ____
Name Phone Number Relationship

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ______________________________ Occupation: ______________________

Address: ____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: ____________________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ ID #: ________________ Group #: ______________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ____

____

Secondary

Name of Insured: ____________________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ ID #: ________________ Group #: ______________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ______________

Social Security #: __________________________ Birth Date: ____________________

Phone (Home): ____________ (Work): ____________ Ext: ______ Best time to call: ____________

Address: ____
Street Apartment #

____
City State Zip Code

Health Information

Date of Last Dental Visit: ____________________ Reason for this visit: ______________________________

Have you ever had or currently have any of the following? Please check those that apply:

☐ AIDS	☐ Excessive Bleeding	☐ Liver Disease	☐ Stroke
☐ Allergies(List)________ ________	☐ Fainting	☐ Mental Disorders	☐ Tuberculosis
	☐ Glaucoma	☐ Nervous Disorders	☐ Tumors
☐ Anemia	☐ Growths	☐ Pacemaker	☐ Ulcers
☐ Arthritis	☐ Hay Fever	☐ Pregnancy	☐ Venereal Disease
☐ Artificial Joints	☐ Head Injuries	Due date:________	☐ Codeine Allergy
☐ Asthma	☐ Heart Disease	☐ Radiation Treatment	☐ Penicillin Allergy
☐ Blood Disease	☐ Heart Murmur	☐ Respiratory Problems	OTHER:
☐ Cancer	☐ Hepatitis	☐ Rheumatic Fever	☐ ________________
☐ Diabetes	☐ High Blood Pressure	☐ Rheumatism	
☐ Dizziness	☐ Jaundice	☐ Sinus Problems	☐ ________________
☐ Epilepsy	☐ Kidney Disease	☐ Stomach Problems	

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Name of Physician: ______________________________ Phone: ________________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ______________________________

Please List All Current Medication Currently Taking: ______________________________

____

____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

______________________________ Date: ________________

Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other ________________

Name of person or office referring you to our practice: ______________________________

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

______________________________ Date: ____________ Relationship to Patient: ________________

Signature of patient, parent or guardian

______________________________ Date: ____________ Relationship to Patient: ________________

Signature of guarantor of payment/responsible party

Assessing Your Smile

To assess your personal feelings about your smile, fill in the following questionnaire. It will take just a few moments to answer the questions and provide a blueprint that will help us to determine the type of treatments best suited to your unique situation.

1. Are you pleased with the general appearance of your teeth and smile?
   - ☐ Yes
   - ☐ No

   If no, please explain: ______________________________

2. Are your teeth straight?
   - ☐ Yes
   - ☐ No

   If no, please explain: ______________________________

3. Are there spaces between your front teeth that you dislike?
   - ☐ Yes
   - ☐ No

4. Are you satisfied with the color of your teeth?
   - ☐ Yes
   - ☐ No

   If no, please explain: ______________________________

5. Are you satisfied with the shape of your teeth?
   - ☐ Yes
   - ☐ No

   If no, please explain: ______________________________

6. Are any of your teeth chipped? Hidden? Protruding?
   - ☐ Yes
   - ☐ No

   If yes, please explain: ______________________________

7. Are you satisfied with the way your teeth come together (bite)?
   - ☐ Yes
   - ☐ No

   If no, please explain: ______________________________

8. Are your gums puffy, red or swollen-looking? Do they bleed easily?
   - ☐ Yes
   - ☐ No

   If yes, please explain: ______________________________

9. Do you have old fillings or dental work that you think would look much better white?
   - ☐ Yes
   - ☐ No

10. Do you have any jagged teeth or teeth that you think are too long or too short?
    - ☐ Yes
    - ☐ No

11. Do you have missing teeth that make chewing difficult?
    - ☐ Yes
    - ☐ No

12. Do you frequently bite the inside of you cheek while chewing food?
    - ☐ Yes
    - ☐ No

13. What would you most like to change about the appearance of your teeth? ______________________________

14. How would you like your teeth to look? ______________________________

DMC

Don M Chaney, DDS, PA.

Cosmetic & Family Dentistry

To better serve our patients we can communicate with you by text and/or email. Please let us know the best way to reach you and provide the **best phone numbers** and **email address** to contact you. Thank you.

Name: ____

Last First Middle

Address: ____

Street Apt #

____

City State Zip Code

Cell _____-_____-_____

Home _____-_____-_____

Work _____-_____-_____

Other _____-_____-_____

My Email Address:

____

I prefer to be contacted:

- **Email**
- **Text**
- **Phone Call**

** The information you have provided us is for our purposes only and will not be shared*

Authorization/Consent for Communication via e-mail/text

Our office offers patient communication by e-mail and text. This form provides information about the risks of e-mail, guidelines for e-mail and text communication and how we use this communication.

We will email correspondence to established patients who are 18 years or older, or the legal representatives of established patients. We use e-mail and text to communicate only about non-sensitive and non-urgent issues.

I have elected to communicate with Dr. Chaney and the office staff by e-mail and/or text. I understand the risks of communicating by e-mail, in particular the privacy risks explained in this form. I understand that Dr. Chaney cannot guarantee the security and confidentiality of e-mail and text communication. They cannot be responsible for messages that are not received or delivered due to technical failure, or for disclosure of confidential information not caused by intentional misconduct.

I have read and understand this form. I understand and agree with the information contained in this form and give my consent for e-mail and text communication to and from Dr. Chaney.

______________________________ ______________________________

PATIENT NAME (PLEASE PRINT) E-MAIL ADDRESS

______________________________ ______________________________

SIGNATUTRE DATE

Don M Chaney, DDS, PA.
Cosmetic & Family Dentistry

ASSIGNMENT OF BENEFITS AGREEMENT

Our office will accept an assignment of benefits from your insurance company with the provisions listed below. It is important to understand, though, that the agreement regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort save you time and to facilitate payment to our office from your insurance company. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.
- We require you to pay the estimated co-payment, which is the amount not covered by your insurance company, at the time we provide service to you. The co-payment is only an estimate of charges and may be found to be insufficient after review by your insurance company.
- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the entire balance at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
- Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I HAVE READ AND ACCEPT TERMS AND CONDITIONS OF THIS ASSIGNMENT OF BENEFITS AGREEMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE DOCTOR.

____
Signature of Insured

____
Please Print Name

____
Date

CONSENT FOR TREATMENT AND PRACTICE POLICIES

Practice Policies

Initial_____ I understand that I will notify the practice if my contact information or insurance should change **prior** to the beginning of any appointment and/or treatment.

Initial_____ I understand that I will be given a full comprehensive dental treatment plan in writing whenever any treatment is recommended by the doctor. If treatment is extensive, the comprehensive treatment plan might be divided and given to the patient in two parts. The first part will be Phase I therapy to increase the patient's health (i.e. remove disease). The second part will be Phase II therapy to restore function (i.e. implants, bridges, veneers, partial dentures...). The quoted costs within the dental treatment plan will be valid for three (3) months. All cost of all personalized dental treatment will be fully discussed before personalized dental treatment begins.

Initial_____ I understand that if I am a relative, caregiver or emancipated minor I must provide legal documentation authorizing the relative, caregiver or emancipated minor the right to consent to dental treatment.

Initial_____ I understand that my dental records are the possession of the practice. The patient has the legal right to request their dental records at any time as described in the Notice of Privacy Practices. The dental records will be provided to the patient within a reasonable time. A nominal administrative charge, which is currently nineteen dollars ($19.00), will be incurred for the time and effort of the staff member (s) to assemble these records for the patient.

Initial_____ I hereby acknowledge that a copy of the Notice of Privacy Policy for Don M. Chaney DDS is available to me upon request for my review. This notice describes how health information about the patient is used and disclosed. This notice also describes how you can have access to this information upon request.

Initial_____ I understand that rude behavior, unruly activity, sexual harassment and profanity will not be tolerated. These actions will be grounds for immediate dismissal from this practice.

Appointment Policy

Initial _____ I understand that Dr. Chaney is a private practice dental office and appointment time is reserved for you alone. We send email and/or text reminders for your reserved appointment for your convenience. If you choose not to respond to text or email you will be given a reminder call for your scheduled appointment. We cannot guarantee that your scheduled appointment will be held if you do not confirm your reserved appointment.

Initial _____ I understand that emergencies, illness, and unplanned issues can come up and I may need to cancel an appointment. If that occurs we respectfully ask for scheduled appointments to be cancelled at **minimum forty-eight (48) hours** in advance. I understand that unfortunately Dr. Chaney and staff can not determine the validity of each emergency, illness or unplanned issue therefore we must adhere to our forty eight (48) hours notice if you choose to change or cancel your appointment.

Initial _____ I understand that if I schedule an appointment and then cancel the appointment within less than **forty-eight (48) hours** of verbal or written (email) notice given to the dental practice, this cancellation will be considered a broken appointment.

Initial _____ I understand that if I make an appointment and do not show up for the appointment this will be considered a broken appointment.

Initial_____ I understand that if I cancel an appointment less with than forty-eight (48) hours notice or no show for an appointment that it is the policy of Don M. Chaney, DDS to ask for pre-payment to reserve any appointment in the future or we may request that your appointment be placed on a call list and we will call you for an appointment the day of an opening on our schedule.

Initial_____ I understand that I will be contacted prior to my appointment for confirmation. I understand that if I do not confirm my appointment may not be guaranteed.

Initial_____ I understand that if I arrive later than fifteen (15) minutes for an appointment this may be considered a broken appointment. Considering this a broken appointment is under the discretion of the doctor on the day of the occurrence, and the current patient load on the daily schedule may factor into the doctor's decision whether or not the doctor or hygienist will still see me for my appointment.

Authorization/Consent for Communication via e-mail/text

Initial_____ I understand that Dr. Chaney and staff conveniently communicates with patients by email and/or text. Dr. Chaney and staff will email correspondence to established patients who are 18 years or older, or the legal representatives of established patients. Dr. Chaney and staff use email and/or text to communicate only about non-sensitive and non-urgent issues.

Initial_____ I have elected to communicate with Dr. Chaney and the office staff by email and/or text. I understand the risks of communicating by email, in particular the privacy risks explained in this form. I understand that Dr. Chaney cannot guarantee the security and confidentiality of emails and text communication. Dr. Chaney or staff cannot be responsible for messages that are not received or delivered due to technical failure, or disclosure of confidential information not caused by intentional misconduct.

Financial Policy

Initial_____ I understand that any unpaid balance will be sent to a collection agency after ninety (90) days. Unpaid balances will include any and all broken appointment charges and/or treatment rendered. Statements for any unpaid balances will be mailed to the patient at thirty (30), sixty (60) and ninety (90) day intervals.

Initial_____ I understand that payment is due the day treatment is rendered. We do not take or make in office payments. We do offer Care Credit as an option for patients who would prefer payments. With Care Credit we can offer up to twelve (12) months interest free as an option for qualifying patients.

Initial_____ Don M. Chaney DDS accepts cash, personal check, credit card (Visa, MasterCard, American Express and Discover) and Care Credit. Payment is due the day services are rendered.

Initial_____ Just as every patient is individual, so is each insurance policy. For patients with dental insurance, we are happy to work with your dental insurance carrier to maximize your annual benefits. As a courtesy for all of our patients Dr. Chaney and staff will directly bill the dental insurance carrier for reimbursement for your personalized dental treatment. However, all dental insurance plans are agreements between the patient and the carrier that provides coverage for the patient and we cannot guarantee payment from the insurance company. Dr. Chaney and staff have no control over what can be and cannot be covered on individual dental insurance policies. The patient has the ultimate responsibility to understand the dental insurance policy they have purchased and accepts responsibility for the full amount of charges incurred for their treatment. Any estimate is not a guarantee of payment. The patient is fully responsible for any amount not covered by the insurance carrier.

Initial_____ Don M. Chaney, DDS charges a twenty - five dollar ($25.00) fee for each returned personal check(s). Once the personal check is returned, no further personal checks will be accepted. All future payments must be made with a credit card or cash. If you have any questions, please do not hesitate to ask.

Dr. Chaney and his dental team are here to help you receive the dentistry you need and deserve. Thank you for the opportunity to help you meet your oral health goals.

By initialing and signing the consent for treatment and practice policies form you, the patient, verify that you have asked our doctor and/or staff all questions regarding additional information needed to fully understand the previous statements. You also consent for this practice to treat your oral health care needs and have the legal right to do so for yourself or for the patient if they are less than 18 years of age, an emancipated minor or incapable of making decisions regarding their health care (caregiver).

____
Print Patient Name

____
Patient Signature

____
Today's Date

______________________________ ______________
Parent/Guardian's Signature Relationship

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to advise you of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. A copy will be provided upon request.

I acknowledge that I have been made aware of this office's Notice of Privacy Practices. I may refuse to sign this Acknowledgement, if I wish.

Signature: ______________________________ Date: ________________

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ______________________________

Relationship to Patient: ______________________________

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

_____ The patient refused to sign.

_____ Due to an emergency situation, it was not possible to obtain an acknowledgement.

_____ Communication barriers prohibited obtaining the acknowledgement

_____ Other, please specify details:

____

____

____

Employee Signature: ______________________________ Date: ________________

Personal Health Information Disclosure Agreement for Don M. Chaney DDS, PA

I, ______________________________, do hereby grant permission for Don M. Chaney DDS, PA, to disclose my personal health information to the following personal representatives(s):

(spouse, sibling, parent, child, friend, etc.)

____

____

____

____

Information to be disclosed (please check):

- o Appointment dates and times
- o Treatment plans and referrals
- o Financial and billing information
- o Any other pertinent dental health information related to treatment at this office.
- o None of the above

....

I understand that this permission will remain in effect unless a written cancellation has been provided to Don M. Chaney DDS.

______________________________ ______________________

Patient Signature Date

____

Patient's Date of Birth

______________________________ ______________________

Witness Signature Date