Office Policy

PAYMENTS:
Payment will be expected at the time of service for all non-contracted fees and co pays.

Insurance contracts: If we have a "Participating Contract" with your Insurance carrier, we will accept assignment on all Covered Services and bill your Carrier for you. You are responsible for the Co-pay, Co-Insurance, Deductible and for all non-covered services.

Insurance plans represent a contract between you and the insurance company. They are not between the doctor and the Insurance Company. We will do our best to help you maximize on you available benefits, but we will not be responsible if your Carrier does not pay. Further, if a member of our staff tells you that you are fully covered or implies that you will owe nothing, it is your responsibility to contact your insurance company for verification. It is also your responsibility to make certain your carrier makes prompt payment, and to handle any disputes that may arise.

If your insurance has not paid the **FULL BALANCE** within 45 days from the date of service, you are asked to pay the balance in full. A finance charge of 18% APR (1.5% a month) will be added to the total balance on all accounts over 60 days past due.

At no time do we ever want to be in this situation. But, in the event that your account is seriously past due. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonably attorneys' fees, we incur in such collection efforts.

If at any time you have questions regarding any treatment, fees, or services, please discuss them with us promptly. We will make every effort to avoid a misunderstanding, to rectify an injustice, or to preserve a friendship.

Missed appointments: Our policy is to charge for missed appointments unless a cancellation is received at least 24 hours in advance. **The charge is $50 per hour of scheduled time – Monday through Friday.**

Children in the office: *Please make arrangements for your non-scheduled children prior to your visit. Children should not be left unattended in the reception area. All children 17 years of age and under scheduled for treatment must have a parent or legal guardian present in the office during their appointment.*

Cellular phones: We request all cellular phones / I Pads / Laptops be turned off or to silent mode during your appointment.

Family/Friends: For the safety and comfort of our patients and team members, no friends or family members will be permitted to accompany patients in the treatment area during the appointment. Any patients with special needs can make necessary arrangements with the office manager prior to your appointment.

We reserve the right to dismiss any patient from our practice for non-compliance or for inappropriate behavior in our office or on the phone.

I have read the policies and agree with the terms outlined above. I acknowledge that I am responsible to pay all charges for treatment administered by Eicon Dental as outlined above.

Responsible Party Signature: _____

Printed Name: _____Date: _____

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Welcome to our Office

PATIENT INFORMATION

First Name: **Initial**: **Last** Name: Date of Birth: / /

Home Address: Apt # City: State: Zip:

Cell / Text Phone # ( ) Home Phone # ( ) Work Phone # ( ) Ext. #

DL # Email: Social Security #: - - Sex: (M) (F)

Employer Name: Position: How Long?

Employer Address: Employer Phone # ( ) Ext. #

In case of an Emergency, contact (Name) Cell Phone # ( )

In case of an Emergency, contact (Name) Cell Phone # ( )

Responsible Party (if other than Patient)

First Name: Initial: **Last** Name: Date of Birth: / /

Home Address: Apt # City: State: Zip:

Cell / Text Phone # ( ) Home Phone # ( ) Work Phone # ( ) Ext. #

DL # Social Security #: - - Sex: (M) (F)

Employer Name: Position: How Long?

Employer Address: Employer Phone # ( ) Ext. #

Primary Insurance Information

Insured First Name: Last Name: Phone # ( ) - Date of Birth: / /

Home Address: Apt # City: State: Zip:

Relationship to Insured (Circle): Self Spouse Child Parent - Sex: (M) (F) Social Security Number:

Insurance Co. Address: Effective Date

Group #: ID #: Phone Number of Insurance Co.: ( )

Who may we thank for referring you?

First Name: **Last** Name:

Home Address: Apt # City: State: Zip:

Home Phone # ( ) Cell/Text Phone # ( ) Work Phone # ( ) Ext. #

I request that all dental benefits, if any, otherwise payable to me for services rendered to be paid to the provider of service. I understand that I am financially responsible for all charges if insurance proceeds are insufficient to cover my obligations and/or a procedure, I am liable for the shortfall. I authorize the provider of service to release all information necessary to secure the payment of benefits. I also consent to the examination and/or treatment of myself and all minor children listed by doctors, doctors' assistants and other medical personnel. Failure to provide complete information may result in my receiving a bill for services.

I am aware that by signing below I certify that all information is complete and correct. This dental office may verify this information from whichever sources it deems necessary (including, but not limited to, credit reports) and may provide others with information regarding my credit history (or the credit report) to the extent permitted by law. This is my authorization for this dental office to verify credit history.

X **X**

Signature of Patient Date Signature of Responsible Party Date

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to.

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

- Obtain payment from third-party payers.

- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and *disclosures of my health information*. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date	Initials:	Reason:

icon Dental
Family | Cosmetic | Oral Surgery

NAME:_____

NEW PATIENTS DENTAL HEALTH HISTORY

Why have you come to see us today? (e.g.: pain, checkup, etc.) _____
Previous Dentist _____ Last Visit _____ Date of last Cleaning _____
Reasons for changing dentists?_____
What problems have you had with past dental treatment _____
Are you nervous about seeing a dentist? ___ Yes ___ No If yes please, tell us why: _____
How often do you brush? _____ Do you floss? ___ Yes ___ No How often? _____

(Please circle each)

Y	N	I clench or grind my teeth during the day or while sleeping.	Y	N	My gums feel tender or swollen.
Y	N	My gums bleed while brushing or flossing.	Y	N	I have problems eating.
Y	N	I would like to improve my smile.	Y	N	I have had orthodontics.
Y	N	I have had a facial or jaw injury.	Y	N	I prefer tooth-colored fillings.
Y	N	I avoid brushing part of my mouth due to pain.	Y	N	I want my teeth straighter.
			Y	N	I want my teeth whiter.

What are your dental priorities? _____

NEW PATIENTS MEDICAL HISTORY

I consider my health to be (check one) ___ Good ___ Fair ___ Poor

Do you have or have you had any of the following? Please circle Y for yes or N for no.

1	Y	N	Heart Disease	25	Y	N	Liver Disease	39	Y	N	HIV
2	Y	N	Heart Murmur/Mitral Valve Prolapse	26	Y	N	Jaundice	40	Y	N	AIDS
3	Y	N	Stroke	27	Y	N	Hepatitis: Type _____	41	Y	N	Immune Suppressed Disorder
4	Y	N	Congenital Heart Lesions	28	Y	N	Diabetes	42	Y	N	Hearing Loss
5	Y	N	Rheumatic Fever	29	Y	N	Excessive Urination and/or Thirst	43	Y	N	Fainting Spells
6	Y	N	Pacemaker	30	Y	N	Infectious Mononucleosis (Mono)	44	Y	N	Giaucoma
7	Y	N	Stent	31	Y	N	Herpes	45	Y	N	History of Emotional or Nervous Disorder
8	Y	N	Abnormal blood pressure	32	Y	N	Arthritis	**WOMEN:**			
9	Y	N	Anemia	33	Y	N	Sexuall Transmitted/Venereal Diseases	46	Y	N	Are you taking birth control medication?
10	Y	N	Prolonged Bleeding Disorder	34	Y	N	Kidney Disease	47	Y	N	Are you or could you be pregnant or nursing?
11	Y	N	Tuberculosis/or Lung Disease	35	Y	N	Tumor or Malignancy				
12	Y	N	Asthma	36	Y	N	Cancer/Chemotherapy				
13	Y	N	Hay Fever	37	Y	N	Radiation/Therapy				
14	Y	N	Sinus Trouble	38	Y	N	History of Drug Addiction				
15	Y	N	Epilepsy/Seisures								
16	Y	N	Ulcers								
17	Y	N	Implants/Artificial Joints: Hi-Knee _____ Other _____								
18	Y	N	I smoke or use chewing tabacco. If yes, how much per day? ___ How many years? ___								
19	Y	N	I have consumed alcohol within the last 24 hours								
20	Y	N	I usually take antibiotic prior to dental treatment								
21	Y	N	Have you ever taken Fen-Phen or Redux?								
22	Y	N	Do you take or have you ever taken Bisphosphonates (Fosamax, Bonivia, Actonel, Aredia, Zometa, etc.) for Osteoporosis or any other condition?								
23	Y	N	I have had major surgery. Year _____ Type of operation _____ Year _____ Type of operation _____								
24	Y	N	Do you have any other medical problems or mental history NOT listed on this form?								

Are you allergic to any of the following?				**Please list all medications you are currently taking:**	
48	Y	N	Aspirin	Medicine _____	Condition _____
49	Y	N	Ibuprofen	Medicine _____	Condition _____
50	Y	N	Sulfa Drugs/Sulfites/Sulfides	Medicine _____	Condition _____
51	Y	N	Penicillin	Medicine _____	Condition _____
52	Y	N	Codeine	Physician's Name _____	Phone _____
53	Y	N	Latex, Metals, Plastics	Address: _____	Fax _____
54	Y	N	Local Anesthetics (i.e., Novacain, Lidocaine	Other: _____	
55	Y	N	Other Medications - Which ones?		

In the event of an emergency please contact:

Name _____ Relationship _____ Phone # _____
Name Relationship Phone #

Initial medical/dental helath reviewed by:			
X _____		/	/
Doctor's Signature	*Date*	*OFFICE USE - Blood Pressure*	*Patient's Signature* *Date*
Periodic medical/dental health reviewed by:			
X _____		/	/
Doctor's Signature	*Date*	*OFFICE USE - Blood Pressure*	*Patient's Signature* *Date*