

# Morgan-Hill Dental Care



If you have dental insurance you would like us to help you with, please notify us before you are seen for your appointment.  
Thank You

## ABOUT THE PATIENT

Today's Date \_\_\_\_\_

Patient Name \_\_\_\_\_

First Last

Name Prefer To Be Called \_\_\_\_\_

Male Female

Mailing Address \_\_\_\_\_

Street/Box #/Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ ext \_\_\_\_\_

Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

Date of Birth \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Circle Marital Status:

Single Married Widowed Partnered Divorced

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

Are you a full time student? \_\_\_\_\_

If Yes, Name and Address of School \_\_\_\_\_

Who should we contact in case of an emergency?

\_\_\_\_\_ Relationship to you \_\_\_\_\_

Phone Number \_\_\_\_\_

Name of Physician \_\_\_\_\_

Physician Phone Number \_\_\_\_\_

Office Location \_\_\_\_\_

## SPOUSE OR PARENT INFORMATION

Name \_\_\_\_\_

First Last

Relationship to Patient: \_\_\_\_\_

Address \_\_\_\_\_

Street/Box #/ Apt. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

Work Number \_\_\_\_\_ ext \_\_\_\_\_

Date Of Birth \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

## HOW DID YOU HEAR ABOUT US?

Mailing  Radio  Website  TV

Yellow Pages  Sign  Patient \*

\* If someone referred you, please list their name & relationship to you \_\_\_\_\_

## DENTAL INFORMATION ON PATIENT

Please check if you have any of the following problems:

Discomfort, clicking or popping in jaw

Red, swollen or bleeding gums

Sensitive tooth, teeth or gums

Blister/sores in or around mouth

Broken/chipped tooth or teeth

Bad Breath  Locking jaw  Stained Teeth

Ringing in ears  Grinding Teeth

Unhappy with the appearance of your teeth

If yes, explain what you are unhappy with:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of previous dentist? \_\_\_\_\_

Do your parents have gum disease or have they lost teeth due to gum disease? \_\_\_\_\_

Have you ever used a C-PAP? \_\_\_\_\_

Has C-PAP ever been recommended to you? \_\_\_\_\_

Ever been told you stop breathing in your sleep? \_\_\_\_\_

Do you ever wake up gasping? \_\_\_\_\_

Are you often tired during the day? \_\_\_\_\_

Fall asleep during the day? \_\_\_\_\_

Do you have headaches in the morning? \_\_\_\_\_



# MORGAN-HILL DENTAL CARE

## INSURANCE INFORMATION

To enable us to help you with your insurance, please provide us with the following information:

Name of the employee: \_\_\_\_\_

Name of the Employer you have the insurance through: \_\_\_\_\_

Name of the Insurance Company: \_\_\_\_\_

Insurance Company Telephone Number: \_\_\_\_\_

Insurance Company mailing address for claims: \_\_\_\_\_

Insurance Company payor ID number for electronic claims: \_\_\_\_\_

Special ID number for the employee: \_\_\_\_\_

Group Number: \_\_\_\_\_

Social Security number of the Employee: \_\_\_\_\_

Benefit Year: \_\_\_\_\_ Maximum: \_\_\_\_\_ Deductible: \_\_\_\_\_

Waiting Periods: \_\_\_\_\_

Coverage for Preventive: Preventive: \_\_\_\_\_ % Basic: \_\_\_\_\_ % Major: \_\_\_\_\_ %

# MORGAN-HILL DENTAL CARE

## Financial and Scheduling Responsibilities

Dental Treatment is an excellent investment in an individual's medical and psychological well-being. To provide you with the highest quality dental care on a sound business basis, we provide our patients with an estimate of fees and arrange for a payment schedule. The purpose of this agreement is to clarify the financial and scheduling responsibilities so we can devote our efforts to helping you achieve and maintain the healthy smile you deserve.

**Insurance:** All professional services rendered are the responsibility of the patient. As a courtesy to you, we will file your insurance claim, although **you are responsible for all charges incurred, not your insurance company.** Your claim will be filed the day of service. We provide your insurance company with all of the information necessary for them to process your claim. If insurance denies your claim or takes longer than 60 days to pay, we ask that you pay your balance in full and collect the money due from your insurance company.

**Billing:** **We do not bill, we ask for payment at the time of service.** We ask that our patients not have an outstanding balance. With the only exception being from a pending insurance claim for up to 60 days. Any account balance over 60 days will be subject to interest charges of 1.5% per month, plus any legal or collection fees.

**Financial Arrangements:** In order to help you obtain the dental health you desire, we have several payment options, as outlined below:

- Pre-Payment Discounts: These are given for treatment plans in excess for \$250 when they are paid in full when making the appointment at least 2 weeks prior to your scheduled appointment.
  - 5% courtesy will be given when using cash or check or debit card. A \$25 service charge will be placed for any and all returned checks
  - 3% courtesy will be given for using a credit card. We accept MasterCard, Visa, Discover, and American Express.
- Extended payment plans:
  - CareCredit: Deferred interest plans for up to 12 months depending on the amount charged. 24-60 month payment plans with interest depending on the amount financed. Quick approvals. **DenVantage savings cannot be applied when using CareCredit.**
  - Personal Credit Cards: See above pre-payment discount section. By using your own credit card, you can save money and budget your payments as you wish
- Installments: Make payments on your account and when treatment is paid for, schedule your appointment.

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# MORGAN-HILL DENTAL CARE

## PATIENT CONSENT FORM HIPAA

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 been informed by you and your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent.

I understand that the organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the organizations at any time to obtain a current copy of the Notice of Privacy 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 agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

# MORGAN-HILL DENTAL CARE

**Appointment Guarantee:** When you schedule an appointment, this time has been reserved exclusively for you. We ask that all rescheduling requests are made at least 2 business days prior to the appointment. Any and all appointments rescheduled without proper notice will incur a \$40 rescheduling fee. For appointments scheduled that have been made with one of the doctors and are longer than 3 hours will incur a \$125/hr fee. DenVantage members will also be required to pay the regular fee schedule, losing member benefits for the scheduled appointment.

In return, if we need to reschedule your appointment without giving proper notice, we will credit your account \$40.

I have read and understand the payment and financial responsibilities as outlined in this form:

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# MORGAN-HILL DENTAL CARE

## AUTHORIZATION & RELEASE OF TESTIMONIAL INFORMATION

**Date:** \_\_\_\_\_

I understand my testimonial as outlined above (the "Testimonial") and made on behalf of Morgan Dental Care (hereinafter called "The Practice") may be used in connection with publicizing and promoting The Practice. I authorize The Practice to use my name, photos and/or video, and the Testimonial as defined on this form.

I hereby irrevocably authorize The Practice to copy, exhibit, publish or distribute the Testimonial for purposes of publicizing The Practice's services or for any other lawful purpose. These statements may be used in printed publications, multimedia presentations, on websites or in any other distribution or social media. I agree that I will make no monetary or other claim against The Practice for the use of the statement.

In addition, I waive any right to inspect or approve the finished product, including written copy, wherein my testimonial appears.

I hereby hold harmless and release The Practice from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

Signature: \_\_\_\_\_

I have read the authorization and release information and give my consent for the use of my testimonial as indicated above.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Email: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Decline Social Media publications: \_\_\_\_\_