Patient Information & Consent Form

Date: _____

Please GIVE THE RECEPTIONIST your Insurance card and Driver's License or other form of ID to be scanned into your patient file.

Name _____ **Date of Birth** _____/_____/_____

Address: _____

***Social Security#**(*needed for insurance claims*)_____**Person Financially Responsible**_____

Home # _____ **Cell Phone #** _____

Permission to leave a message on your Home # Yes or No _____**initials**

Permission to leave a message on your Cellular # Yes or No _____**initials**

Email Address _____ **Email Reminders and Statements: Y or N**
(Note: E-mails are password protected, they are not encrypted)

Emergency Contact _____ **Relation to Patient**_____

Emergency Contact Phone Number_____

Patient's or Guardian's Employer Name: _____

Who can we thank for referring you to us? _____

Dental Insurance Information

Primary Dental Insurance _____ **Group #** _____

Policy Holder Name:_____**Policy Holder's Employer:**_____

Policy Holder's Social Security #* _____ **Policy Holder's Member ID:** _____

Policy Holder's Date of Birth: _____/_____/_____

Insurance claims cannot be submitted without the Policy Holder's Social Security Number. If patient refuses to release this information, full fees will be collected at time of service and patient will be responsible for submitting insurance claim.

Notice of Privacy Practices

I acknowledge Albright Dental Practice's Notice of Privacy Practices (HIPAA) Law for myself and my dependent children.

Signature: _____ Date: _____

I have been made aware that Dr. Albright's Cancellation Policy for appointments requires 48 business-hours notification. Failure to cancel within that designated time results in a $50.00 missed appointment fee.

Signature: _____ Date: _____

Time 10:52 AM

Dr. John Albright

Date 1/12/2015

Eaglesoft Medical History

Patient Name: _____ Birth Date: ____/____/____ Date Created: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes No	If yes	
Have you ever been hospitalized or had a major operation?	Yes No	If yes	
Have you ever had a serious head or neck injury?	Yes No	If yes	
Are you taking any medications, pills, or drugs?	Yes No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes	
Are you on a special diet?	Yes No		
Do you use tobacco?	Yes No		

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes	
Do you use controlled substances?	Yes No	If yes	

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
						Yellow Jaundice	Yes No

Have you ever had any serious illness not listed	Yes No	If yes	

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____ Date: _____

Albright Dental Practice - Dr. John H. Albright, D.D.S.

Financial Policy

It is the policy of Albright Dental Practice to have a Financial Policy that clearly outlines patient and practice responsibilities. We are committed to providing our patients with the best possible dental care while minimizing administrative costs. This Financial Policy has been developed with these objectives in mind, and to avoid any misunderstandings or disagreements concerning payment for professional services.

Please read the following carefully:

For all patients:

- Appointments missed or not cancelled within 48 hours will incur a $50.00 "Failed Appointment" Fee.

For patients who do not have insurance:

- Patients who do not have any insurance coverage are **expected to pay for services rendered at the time of visit.** Financial assistance may be available for qualified patients. If a patient feels that he or she may qualify for assistance, it should be discussed with the financial administrator **at the appointment check in, not after services are rendered.**

For patients who are currently covered by insurance:

- The patient is responsible to provide us with **valid dental insurance information, and should bring their insurance card to each visit.** The patient is responsible for notifying us of **insurance changes or new insurance information at the time of check-in for your visit.**
- Our office participates with Delta Dental Premier, MetLife, Aetna and NCAS. **As a courtesy we will process claims for most dental insurances** unless we are not able to submit to them because of out of network agreements. For patients that are members of a participating insurance, we will submit a claim on their behalf to the insurance company.

If you have a plan that our practice participates with:

- The **patient is responsible to pay any co-payment** or any portion of the charges as specified by the plan **at the time of visit**.
- Any dental services not covered by an individual's insurance plan are the patient's responsibility and payment in full is due at the time of visit.

If you have a plan that our practice does not participate with:

- If a patient has insurance that we do not participate in, we will submit a claim to the insurance company on your behalf (as a courtesy) and the difference in payment (if any) will be the patient's responsibility.
- If a patient is a member of an insurance company that mails the payment for service directly to the patient; then the patient is responsible for payment at time of service and their insurance company will send their reimbursement (if any) to their residence.

Financial responsibility:

- Any outstanding patient balance that is either not paid in full or under a payment plan agreement will be transferred to an outside collection agency if the account balance is not paid in full or the payment plan is not upheld by the patient.
- The patient is responsible for contacting Albright Dental Practice to inform us of any address or phone number changes. Failure to report a current address and phone number with an unpaid balance will result in an outside collection agency acting on our behalf.

Concerns about dental coverage:

- Albright Dental Practice submits claims and pre-determinations to a patient's insurance company on the patient's behalf as a courtesy; however, **we do not** have an agreement of coverage with your insurance company. The agreement for coverage is between the patient and the patient's insurance company. If a patient has a concern with coverage, please contact the patient's insurance company.
- Albright Dental Practice is not responsible for what insurance companies cover or do not cover. Our concern is with providing our patients with the best dental care possible. Additionally, it is the patient's responsibility for tracking remaining benefits. You will receive your remaining benefits at the bottom of every explanation of benefits document that you receive by mail from your insurance company directly.

My signature on this document confirms that I have read and will adhere to Albright Dental Practice Financial Policy Agreement for myself and dependent children:

_____**(signature)** _____/_____/_____**(date)**

_____**(print name)**

Dr. John H. Albright, D.D.S.
2804 Walbert Ave
Allentown, PA 18104
610-821-8024
610-821-8084
jhalbright@rcn.com

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name: _____

Patient address: _____

Patient phone number: _____

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released: x-rays, insurance coverage, health information, etc.
2. To whom may the information be released: Oral Surgeon, Endodontists, Specialists, etc.
3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual): Doctor's referral.
4. List Name of person(s) to release medical information to: _____
5. Expiration date or event relating to the individual or purpose for the release: none

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient/Guardian signature_____ Dated_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____Print Name_____