Patient Registration

Last Name: First Name: Middle Initial .

Address: Date of Birth .

City: State: Zip :

Telephone Number: (Work): (Cell) :

Email address :

Social Security Number Driver’s License Number ..

How did you hear about our office? .

|  |  |
| --- | --- |
| Insurance Information  | Secondary Information  |
| Subscriber Name  | Subscriber Name  |
| Subscriber ID | Subscriber ID |
| Date of Birth  | Date of Birth  |
| Relationship to Subscriber  | Relationship to Subscriber  |
| Employer Name  | Employer Name  |
| Employer Phone  | Employer Phone  |
| Insurance Company | Insurance Company  |
| Insurance Group  | Insurance Group  |
| Insurance Phone  | Insurance Phone  |

**Responsible Party (if minor)**

Last Name: First Name: Middle Initial

Address: Date of Birth :

City: State: Zip :

Telephone Number: (Work): (Cell) :

Email address :

**AUTHORIZATION.** I consent to the diagnostic procedures and dental treatment performed by my dentist and to the release of information concerning my (or my child’s) health care, advice and treatment to another dentist or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

**ELECTRONIC COMMUNICATIONS.** I consent to receiving HIPPA-compliant electronic communications, such as email and text messages regarding treatment, payment and health care operations. I understand that there is no obligation to receive these electronic communications. Message/ data rates may apply and I may opt-out of receiving electronic communications at any time.

**Patient Signature: Date :**

**COMPOSITE FILLING DISCLOSURE.** I understand that Dr. James Durfey, DDS, only uses composite (tooth colored) filling material for fillings on teeth. I further understand that most insurance companies **DO NOT** pay a full benefit for the composite fillings, and therefore I **WILL** be responsible for the difference in cost for any fillings that are done in this office.

**TREATMENT DISCLOSURES.** I understand that individual reactions to treatment can not be predicted. If I experience any unusual reactions during or following procedures, I will report them to the office immediately.

Anesthetizing agents (medications) are injected into a small area with the intent of numbing the area to received dental treatment. They also can be injected near a nerve to act as a nerve block causing numbness to a larger area of the mouth beyond just the site of injection. It is normal for the numbness to take time to wear off after treatment, usually two to three hours. This can vary depending on the type of medication used. However, in some cases, it can take longer, and in some rare cases, the numbness can be permanent if the nerve is injured. Infection, swelling, allergic reactions, discoloration, headache, tenderness at the needle site, dizziness, nausea, vomiting, and cheek, tongue, or lip biting can occur.

**MISSED APPOINTMENTS**. Unless cancelled at least 48 hours in advance, our policy is to charge for missed appointments at the rate of 50.00 per appointment. Further more consequences such as not being able to reserve time on the schedule in advance, only being able to schedule at the end of the day, and not allowing family members to be scheduled on the same day are all possible consequences of missed appointments and it is the staff’s discretion to apply consequences as needed.

**UNCONFIRMED APPOINTMENTS.**  We go through great lengths to confirm all dental appointments via our automated confirmation system and telephone calls the day before to those appointments still unconfirmed, if you are not confirmed for your appointment, we may double book that time and you may have to reschedule your original appointment.

 **DELINQUENT PAYMENTS**. It is our policy to charge finance fees at the rate of 1.5% for outstanding patient balances after the balance has been outstanding for 30 days. In addition, all payments returned due to non-sufficient funds will be subjected to a fee. Accounts will be turned over to collections after 90 days past due.

**CARD PAYMENT PROCESSING FEE.** We do charge a 3% processing fee for any card payment, if you would like to avoid that fee you may pay with cash or check.

**MEDICARE/MEDICAID AND OTHER GOVERNMENT SPONSORED PROGRAMS**. If you are covered by any government sponsored program, your benefits are still your responsibility to know and you will still receive a bill if the insurance denies a payment.

**Your clear understanding of our financial policies is important to our professional relationship. Please ask if you have any questions about fees, Financial Policies, or your responsibility.**

**-All patients must complete “Patient Registration” before seeing the dental professional**

 **-Full payments are due at time of service**

**-Aztec Family Dental Care provides insurance billing AS A COURTESY to our patients, it is still the patient’s responsibility to know their insurance information and specific plan benefits. The Patient Portion of dental service(s) are ESTIMATES and due at the time of service.**

**Patient Signature Date .**

**NOTICE OF PRIVACY PRACTICES.** You have the right to read the Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practice, we will issue a revised Notice of Privacy Practices, which will contain the changes. These changes may apply to any of your protected health information that we maintain. You will have the right to revoke this Consent at any time by giving us written notice of your revocation