Welcome!

Today's Date___________________________

We would like to welcome you to our office. Our goal is to make everyone's visit pleasant and educational. We strive to teach exceptional oral care that will enable you to have a beautiful smile that lasts a lifetime.

PATIENT INFORMATION

First Name ____________________________MI_____

Last Name _____________________________________

Birthdate_____________________Age____________

Married ___ Divorced ____ Single ____

Address _______________________________________

____

Phone (Home)______________________

(Cell)_________________________

Email ____

RESPONSIBLE PARTY (For children under 18)

Please list names of Mother/Father/Guardian.

____

____

PRIMARY DENTAL INSURANCE

Medicaid or Healthy Kids? Y____N____

Insurance Name _______________________________

Insurance Address______________________________

Insurance Phone_______________________________

Policy #________________Group #______________

Policy Holder Name____________________________

Relationship to Patient________________________

Policy Holder Birthdate_________SSN____________

Employer________________________

HOW DID YOU HEAR ABOUT OUR OFFICE?

Please circle where applicable:

Insurance	Medicaid	Internet/Google
Newsleader	Postcard	Facebook

Friend____

Dr's office____________________________________

Other____

DENTAL HISTORY

Purpose of today's visit_________________________

Previous Dentist_______________________________

Date of last visit_______________________________

What was done_________________________________

Last cleaning__________________________________

How often do you brush?_______________________

Gums bleed? Y____N____

Any concerns?_________________________________

I authorize the doctor to perform all recommended treatment agreed upon by me and to use the appropriate medication and therapy for such treatment in connection with ________________________________ (name of patient).

I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and give consent to the doctor to use and employ such assistant as deemed to provide recommended treatment.

FINANCIAL & OFFICE POLICY

INSURANCE BILLING: (If applicable)

As a courtesy, our staff will attempt to verify insurance plan benefits prior to treatment, however, there may be plan limitations that are not disclosed to our office, such as waiting periods, frequency limitations, age limitations, non-covered services, or procedure downgrades. Verifying your own benefits will help to prevent receiving an unexpected bill after the claim has been processed.

In addition, due to pending claims and patient privacy issues, we do not always know how much an insurance company has already paid to another office or specialist, and the balance remaining on a yearly maximum. When a Treatment Plan is given, please remember that it is an estimate of insurance benefits and if there is any balance after the insurance company's payment, that balance is the responsibility of the patient. If the insurance company pays more than the estimated fee, our office will gladly send you a check for the difference.

It is important to understand that the insurance contract is between the insurance company and you, the insured. Treatment recommended by Dr. Acosta is never based on what your insurance company will pay, but on what's best for you, as a patient.

PAYMENT and DEPOSIT FOR APPOINTMENTS

Payment or Co-payment is due and payable at the time services are rendered.
If an appointment is needed that reserves a one hour time slot, a $100 deposit is required, a 2 hour slot, requires a $200 deposit, paid at the time of scheduling.

Hancock Village Dental gladly accepts Visa, Mastercard, Discover, American Express, Cash, and Care Credit. Checks are no longer an accepted form of payment. Please note: If using Care Credit No-Interest Financing, there is a minimum of $300 for 6 month no interest financing, and a minimum of $700 for 12 month no interest financing.

By providing your signature below, you agree that you have read, understood, and accepted the Financial Policy of Hancock Village Dental.

APPOINTMENT CANCELLATION POLICY

We strive to render excellent dental care to all our patients. When an appointment is scheduled, we reserve that time especially for you. We require that you give our office 48 hours notice (or if your appointment is on Monday, please let us know by Thursday) in the event that you need to reschedule your appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. We reserve the right to charge a $50 fee for a missed appointment, which cannot be billed to your insurance company and will be the responsibility of you, the patient.

If there are more than two no show or same-day cancelations, we are then unable to offer pre-appointments. We invest in technologies that will help with reminders, such as emails and text message reminders, so that there are several ways you can inform our office of any changes to your schedule.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have. We thank you for your understanding.

By providing your signature below, you agree that you have read, understood, and accepted the Appointment Cancellation Policy of Hancock Village Dental.

____ ____________________
Signature of Patient/Parent or Legal Guardian Date

If signed by other than patient, specify relationship to patient:____________________________

Do we have your permission to:

Send a recall appointment reminder to your home? Y________ N________

Leave appointment, billing or dental information on your voicemail/email? Y________ N________

Send text message reminders? Y________ N________

I give permission to share appointment, billing or dental information with the person(s) named below:

Name:___________________________________ Relationship:____________________________

Name:___________________________________ Relationship:____________________________

Name:___________________________________ Relationship:____________________________

____ ___________________

Signature of Patient/Parent or Legal Guardian Date

If signed by other than patient, specify relationship to patient:__________________________________

Acknowledgment of Receipt of Notice of Privacy Practices

I, ________________________________ have received a copy of this office's Notice of Privacy Practices to review.

____ ___________________

Signature of Patient/Parent or Legal Guardian Date

If signed by other than patient, specify relationship to patient:__________________________________

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained:

____ Patient / Parent or Legal Guardian refused to sign form

____Other: ____

____ ___________________

Signature of Office Manager Date