

## Ironwood Dental Care P.C.

### Financial Policy

We have written this information guide to enable our staff to attend to your dental health needs on a more personal level; we hope it will make it easier to understand our office policy regarding your financial obligation. We will try and bill you at the appropriate time and file your insurance claims for you. My staff and I will strive to have open communications on all financial matters. If you have any questions or problems, please bring them to our attention. We are here to help.

**1: Patient care is our primary goal.**

**2:** For patients with insurance, as courtesy, we will file your insurance claim for you. You will be expected to pay your deductibles and co-insurance at each visit, and any portion not covered by your insurance. Please understand that what we collect are only **estimates** and you are ultimately responsible for any and all of the cost of your dental care. After your dental claim is paid, you will be billed for the remaining balance.

**3:** If, after 90 days your insurance company has not paid on your claim, you will be billed for the entire balance.

**4:** Our office reserves appointment times especially for you when you schedule them. If you are unable to make a scheduled appointment with our office, please notify us at least 24 hours prior to your appointment, so that we may schedule another patient at that time. If there is less than 24 hour cancellation notification, there will be a \$50.00 missed appointment charge.

**5:** We suggest that you know the limitation of your insurance. If you are limited, by your insurance plan, to a certain number of visits per year or have contractual waiting periods; please keep track of this information. You will be held responsible for payment.

**6:** We accept MasterCard, VISA, cash, check, and money orders. Any check returned from the bank will be subject to a \$45.00 charge and cash will be required for future visits.

**7:** All first time visits and emergencies; Full payment is due at the time of service.

**8:** Please ask our office staff if you have any questions.

**I have read, understand, and accept that I am responsible for any and all fees that are incurred by me at Ironwood Dental Care, P.C.**

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

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

## Ironwood Dental Care P.C.

### Acknowledgement of Receipt of Notice of Privacy Practices

*\*\*You May Refuse to Sign This Acknowledgement\*\**

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
(Please Print Name)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

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#### For Office Use Only

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

- Individual refused to sign.
- Communication barriers prohibited obtaining the acknowledgement.
- An emergency situation prevented us from obtaining acknowledgement.
- Other. (Please Specify) \_\_\_\_\_

\_\_\_\_\_

Welcome to Ironwood Dental Care. Please fill out this form completely and print clearly.  
If you have any questions we will be glad to help you.

## PATIENT INFORMATION:

Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Mailing Address (if different): \_\_\_\_\_  
Sex: M  F  Age: \_\_\_\_\_ Birth date: \_\_\_\_\_ Marital Status: Single  Married  Widowed   
Patient SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email Address: \_\_\_\_\_  
How would you like us to confirm your appointments? (Multiple is okay) Home  Work  Cell  Email   
Home Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_ Work Number: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ Drivers License #: \_\_\_\_\_ State: \_\_\_\_\_  
If the patient is a student: School Name: \_\_\_\_\_ Grade: \_\_\_\_\_  
How did you hear of the office (passed by, yellow pages, internet, and referral) \_\_\_\_\_?  
Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## ACCOUNT INFORMATION:

Person responsible for this account: \_\_\_\_\_ Relationship: \_\_\_\_\_  
SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth date: \_\_\_\_\_ Drivers License #: \_\_\_\_\_ State: \_\_\_\_\_  
Home Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_ Work Number: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

## INSURANCE:

Name of Insured (person who holds the insurance): \_\_\_\_\_  
SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ Insurance Co.: \_\_\_\_\_ Grp#: \_\_\_\_\_  
Is patient covered by additional dental insurance? Yes  No   
Names: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ Insurance Co.: \_\_\_\_\_ Grp#: \_\_\_\_\_  
Medical Insurance Company: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Grp#: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_

*I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE AND ASSIGN DIRECTLY TO DR. STANLEY ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.*

## ASSIGNMENT AND RELEASE:

I UNDERSTAND THAT IF MY ACCOUNT BECOMES DELINQUENT, AND THIS OFFICE TURNS MY ACCOUNT OVER TO A COLLECTION AGENCY, I WILL BE RESPONSIBLE FOR ANY FEES THAT ARE INCURRED IN THE PROCESS, AS WELL AS THE BALANCE OWED.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

**DENTAL HISTORY**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Check if you have or have had any of the following:

Table with 3 columns of symptoms and checkboxes for Y/N. Symptoms include Bad Breath, Grinding/Clenching teeth, Bleeding or sore gums, Dry Mouth, Mouth Breathing, Lip or Cheek biting, Fingernail biting, Sensitivity to: (circle) COLD HEAT SWEETS when biting? Where? \_\_\_\_\_, Reason for today's visit: \_\_\_\_\_, Former Dentist: \_\_\_\_\_, Date of last visit? \_\_\_\_\_, Date of last dental x-rays taken? \_\_\_\_\_, How many were taken/what type? \_\_\_\_\_, How often do you brush? \_\_\_\_\_, Floss? \_\_\_\_\_, Pain or bleeding after brushing/flossing? \_\_\_\_\_, Have you had a negative reaction to local anesthetic? \_\_\_\_\_, Any anxiety about your dental visit? \_\_\_\_\_, Any teeth giving you pain? (where) \_\_\_\_\_

**HEALTH HISTORY**

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Check if you have, or have had any of the following:

Table with 3 columns of health conditions and checkboxes for Y/N. Conditions include AIDS/HIV, Artificial Heart Valve, Diet Pills/ Phen-Fen, Murmur / Heart Problems, Describe: \_\_\_\_\_, Fosamax, Congestive Heart Failure, High Blood Pressure, Mitral Valve Prolapse, Pacemaker, Rheumatic Fever, Alcohol, drug abuse, Anemia, Angina, Arthritis, Rheumatism, Artificial Joints (knee, hip), Asthma, Back Problems, Blood Disease, Blood Transfusion, Tobacco use: Amount? \_\_\_\_\_, How long have you used tobacco? \_\_\_\_\_, Is there any condition not listed that you have? \_\_\_\_\_, Hepatitis: Type \_\_\_\_\_, Narrow Angle Glaucoma, Chemotherapy/Radiation, Circulatory Problems, Cortisone Treatments, Cough, persistent or bloody, Diabetes, Epilepsy/ seizures, Fainting or dizziness, Glaucoma, Headaches, Herpes, Kidney Disease, Liver Disease, Low Blood Pressure, Cancer, MAOI Drugs, Scarlet Fever, Shortness of Breath, Sinus Trouble, Skin Rash, Special Diet, Stroke, Swelling of feet or ankles, Swollen neck glands, Thyroid Problems, Tonsillitis, Tobacco use:, Tuberculosis, Tumor/growth on head/neck, Ulcer, Respiratory Disease (lung), Venereal Disease, Wear Contact lenses, Weight change- unexplained, Women: Are you pregnant?, Are you nursing?, Using Birth Control Pills?, Other: \_\_\_\_\_

**MEDICATIONS:**

Check here if you are not taking any medications  Below, please list any medications you are currently taking: (Including vitamins and herbal medicines) \_\_\_\_\_ Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

**ALLERGIES:**

Check here if you have no known allergies   Aspirin  Sulfa  Codeine  Valium  Erythromycin  Other: (Food or Medicine)  Latex  Local Anesthetic (Novocain)  Penicillin/Amoxicillin

**CONSENT:**

The information on this questionnaire is accurate to the best of my knowledge. I understand this information will be used by the dentist to help determine appropriate dental treatment. If there is any change in medical status, I will inform the dentist. The undersigned hereby authorizes the doctor, or doctor's staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. Refusal of diagnostic aids at any time will release the doctor of responsibility for early diagnosis. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated.

Patient or Responsible Party (Parent/Guardian of minor) : \_\_\_\_\_ Date: \_\_\_\_\_ Doctor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_