WELCOME!

PATIENT INFORMATION

TODAY'S DATE:_____

Name: _____Birthdate:_____ SSN:_____

Home Phone: (_____)_____ Cell: (_____)_____

_Married _Single _Widowed _Divorced _Separated _Other

Address: _____

_____

Employer: _____ Work Phone: _____

Emergency contact: _____ Phone:(__)_____

Referred by:

RESPONSIBLE PARTY (IF DIFFERENT FROM SELF)

Name of person Responsible for this Account: _____

Relationship to Patient: _____ Birthdate: _____

SSN: _____ Email: _____

DENTAL INSURANCE (PRIMARY/SECONDARY)

PRIMARY SECONDARY

Insured Name: _____ Relationship to Patient: _____ Birthdate: _____

SSN: _____ Employer: _____ Ins. Co Name: _____

Group#: _____ **(IF Secondary)** Insured Name: _____ Birthdate: _____
SSN: _____ Group#: _____ Employer: _____

MEDICAL HISTORY

PATIENT NAME:_____ **Date:**_____

Primary Care Physician's Name: _____Telephone#: _____

Are you currently under the care of a Physician? Yes/No Date of Last visit: _____

Do you **Pre-Med** before dental appointment? Yes/No, If yes (explain) _____

Have you been hospitalized or had a serious illness within the past five years? Yes/No

(explain):_____

Have you ever had blood transfusion? Yes/No (if yes give date)_____

(Women) Are you pregnant or is it likely that you could be pregnant? Yes/No

Circle if you have or ever had:

Artificial limb/joint/hip	Chemical Dependency	Mental Illness	Thyroid disease
Alzheimer's Disease	Dementia	Osteoporosis	Tobacco Habit
Anemia	Diabetes	Osteopenia	Tuberculosis
Asthma	Defibrillator	Pacemaker	Ulcer
Artificial Heart Valve	Epilepsy/Seizures	Parkinson's Disease	Liver problems
Arthritis/Rheumatism	Headaches/injury	Radiation Treatment	
Bleeding Abnormal	Heart murmur	Respiratory Disease	
Bell's Palsy	Heart problems	Scarlet Fever	
Blood thinners	HIV/AIDS	STD	
Chemical dependency	High Blood Pressure	Shortness of Breath	
Cough up Blood	Hepatitis (A, B, or C)_____	Stroke (TIA)	
Cancer (type _____)	Kidney Disorder	Swelling feet/ankles	

List of Medications you are currently taking: _____

_____

Allergies: _____

Provided office with list of meds: _____

AUTHORIZATION AND RELEASE

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry our payment activities in connection with this claim**. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity, Dr. Name or Dental Entity: _____**

_____ Date: _____

(Signature of Patient, Parent, Guardian or Responsible Party)

_____ Date: _____

(Please Print name of Patient, Parent, Guardian or Responsible Party) Dr. Signature: _____

Clermont Dental Group, PA Financial Policy

Please take the time to read the following, **initial each section**, and sign and date the bottom of this form.

_____ Full payment is due at the time of service unless arrangements have been made prior to the start of any treatment.

_____ Insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a courtesy. However, insurance balances which are not paid within 60 days may be billed to you. Please keep your walk-out statements and follow up with your insurance carrier to ensure prompt payment.

_____ Some of your treatment may not be covered by your insurance carrier. The cost for such charges will be your responsibility.

_____ Major services may require a deposit equal to at least one half of the estimated patient portion at the time the appointment is made.

_____ Patients are asked to confirm their appointments at least 48 hours in advance by responding to our confirmation contact. Failure to confirm your appointment may result in your appointment reservation given to another patient.

_____ There will be a fee of $30.00 for any checks returned as Non-Sufficient Funds (NSF)

_____ Patient balances that go unpaid for 30 days or more may incur one or more of the following charges: ***Interest charges of 1.5% per month***

INDEPENDENT CONTRACTOR CONSENT

I,(Patient or guardians name)_____,

Understand that **Dr. Matthew Lasorsa** is employed as an independent contractor within Clermont Dental Group. Dr. Lasorsa is not a provider with any insurance company and all fees charged are Fee For Service and are not subject to any insurance adjustments or negotiations.

(Initial) _____I am also aware that some dental insurances do not have a coordination of benefits, meaning the insurance check may be sent to the patient instead of the provider. If this should happen, I understand that I will be responsible to provide the insurance check to Dr. Lasorsa/staff at Clermont Dental Group.

_____ _____

Signature of Patient/Guardian Date

_____ _____

Signature of Witness/Staff Member Date

PHOTO CONSENT

I consent to Dr. Matthew J. Lasorsa and Clermont Dental Group, PA to use my name, x-rays, photographs, and models for the purpose of case presentation and marketing. Case presentations would include but not limited to continuing education seminars, publications, and study clubs. Marketing would include but not limited to posting on the office website, Newspaper/magazine ads, Postcards, internet marketing, television commercials, infomercials, and TV shows.

Signature of patient/guardian: _____ Date: _____

[__] I DO NOT GIVE PERMISSION TO USE MY NAME/PHOTOS/INFO

PATIENT CONSENT TO RECEIVE MAIL/EMAIL/AND/OR TELEPHONE MESSAGES

_____

(Please Print) (Last name) **(First name)** **(Middle initial)**

I agree that the practice may communicate with me electronically at the following address:

_____ _____

(Phone number) **(E-mail address)**

I consent to receive calls and text messages related to my protected healthcare and other services at the phone number(s) above, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

Do we have your permission to:

- Send a recall appointment reminder to your home? Y_____ N_____
- Leave appointment, billing or dental information on your answering machine/voice mail/e-mail: Y_____ N_____

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

Name: _____

_____ _____

(Signature of Patient/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.

_____ _____

(Signature of Patient/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 because:

[__] Patient / Parent or Legal Guardian refused to sign form
[__]Other

_____

Signature of Office Manager Date

Cancellation/No-Show Policy:

We realize your time is valuable and make every effort to keep you from waiting. As a result, your appointment time in this office is reserved exclusively for you. We reserve the right to charge patients, who do not reschedule with adequate notice, or who fail to keep their scheduled appointments. In order to be respectful of the needs of all patients, if it is necessary to cancel your reserved appointment we require that you contact our office **48 hours** in advance. Appointments are in high demand and your early cancellation will give another person the possibility to access timely dental care.

A 'no-show' appointment occurs when a patient misses an appointment without canceling **48 hrs**. in advance. No-shows inconvenience patients who need access to dental care in a timely manner. Last minute/late cancellations are considered 'no- show' appointments.

Failure to be present at the time of a reserved appointment will be recorded in your patient chart as a 'no show'. The first 'no show' will result in a **$35- fee**. If there is a second 'no show' a **$50-fee** will be billed to your account. A third 'no show' may result in suspension of services and dismissal from our dental practice.

Patient Name Printed: _____

Patient or Responsible Party (signature) _____

Date: _____