Elite Dental Associates

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

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

Email: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:
- ☐ _____
- ☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Medical Log

Date _____

Patient Name _____ Date of Birth _____

Pharmacy _____ Pharmacy Phone Number ( )

Please list ALL medications prescribed and taken on a regular daily basis.

Medication	Strength	Qty	Frequency	Reason for Medication

Please list ALL vitamins and supplements taking on a regular daily basis.

Brand Name	Strength	Qty	Frequency	Reason for medication

_____ _____

Patient Signature Date

Elite Dental Associates
1 Bethany Road
Building 4, Suite 54
Hazlet, Nj 07730

Financial and Scheduling Policies

Thank you for allowing Elite Dental Associates the opportunity to care for your lifetime dental needs. We are excited to partner with you to improve and maintain your oral health. We will be sensitive to your financial and scheduling circumstances and do everything possible to help you achieve optimal oral health. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment. We ask that there is a clear understanding as outlined below of our financial and scheduling policies. Thank you!

Financial Guidelines:

- Payment is due at the time services are rendered. This would include estimated deductibles, co-pays, and co-insurances.
- For your convenience, treatment costs can be paid for with cash, credit card, check, or third party financing.
- Returned checks are subject to a $45.00 fee to cover processing fees incurred by our office.
- Account balances over 60 days are subject to a $35.00 late fee and referral to collection agencies which may also lead to additional charges, fees, and credit implications. In the event an account becomes delinquent, the remaining balance plus the sum of any collection agency fees. In this event, I authorize the release of financially identifiable information concerning my account.
- All emergency dental services and any dental services performed without previous financial arrangements must be paid in full at the time services are rendered.

Patients with Insurance:

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit. We will bill your insurance directly to collect reimbursement for your treatment so that you will receive the full benefits of your insurance coverage. At EDA, we strive to maximize your insurance benefits and help to make any remaining balance easily affordable. Please be advised that any amounts estimated to be paid by insurance providers ***are estimates only***, and that no guarantee can be made by our office regarding these amounts. We will do all we can to ensure your estimate is as accurate as possible. However, insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums/limits which are your responsibility.

Regarding maximums, if you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period as it is possible that some treatment may have been completed outside of EDA. Please contact your insurance company for a detail of your benefits. Your

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insurance company and your plan benefits ultimately determine the amount paid. Your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan. In the event that the amount paid by your insurance(s) differs from the estimate, you will be billed for the outstanding balance.

All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area.

You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Insurance payments are ordinarily received 30-60 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected, at this time the remaining balance will be due and payable by you and you will be responsible for collection of your benefits directly from your insurance carrier. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. I authorize the release of any information concerning my (or my child's) healthcare advice and treatment provided for the purpose of evaluating and administering claims for and with regards to optimal health for our patients. It is our goal to provide our patients with the level of care that they desire and deserve, and we will not allow insurance plans to dictate the level of care we offer to our patients. We maintain that insurance is a method of payment, and not a method of treatment. Elite Dental Associates does not render services on the assumption that our charges will be paid in full by an insurance company.

Deposit Policy: Certain appointments will require a deposit to reserve an appointment time. Appointment times greater than 90 minutes, specialty services, or certain high demand appointment times may require deposit of 50% of the future copay to reserve the appointment time. Remaining balances can be paid at the time treatment is rendered.

Minors: Minors must be accompanied by the parent or legal guardian. The parent or legal guardian accompanying a minor, who has consented to treatment, is responsible for full payment at the time of service. Treatment may be denied if signed treatment plans and financial arrangements are not made by the legal guardian.

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Consent: I have read, understood and agreed to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Communication with you: By signing below, you are authorizing us to call/text/email you at any numbers/address you provide. I authorize the dentist or dental office designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile, or in paper form to my insurance carrier, another oral health provider/ specialist or any other related entities that require such information to be submitted.

Name (please print):_____

Signature:_____Date:_____

Elite Dental Associates
1 Bethany Road
Building 4, Suite 54
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frontdesk.elite@gmail.com
732-264-6202

Notice of Privacy Practices Acknowledgement and Consent

I acknowledge the receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be effective as the original.

My signature will also serve as a PHI document release should I request treatment or radiographs be sent to other attending doctors/facilities in the future.

Your Comments regarding acknowledgement and consent:

I authorize the following individuals (example: spouse, parent/guardian, sibling) to have access to and be informed of this patient's dental/medical information and dental/medical care:

Name:
Relationship to Patient:

Name:
Relationship to Patient:

Name:
Relationship to Patient:

If you do not list anyone, we WILL NOT share information regarding your account.

I authorize contact from this office to confirm my appointments, treatments and billing information via:

O Cell phone confirmation	O Text message to my cell phone
O Home phone confirmation	O Email confirmation
O Work phone confirmation	O Any of the above

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I authorize information about my health be conveyed via:

O Cell phone confirmation	O Text message to my cell phone
O Home phone confirmation	O Email confirmation
O Work phone confirmation	O Any of the above

I approve being contacted about special services, events, fundraising efforts or new health information on behalf of this office via:

O Phone message	O Text and email messages
O Any of the above	O None of the above (opt out)

In signing this HIPPA patient acknowledgement form, I acknowledge and authorize that this office may recommend products or services to promote my improved health. This office may or may not receive third party remuneration from these affiliated companies. This office, under current HIPPA Omnibus Rule, will provide me with this information with my knowledge and consent.

Patient Name:_____ Signature:_____ Date:_____

If not patient:

Name:_____ Signature:_____ Date:_____

Relationship to patient:_____

FOR OFFICE USE ONLY:
As a privacy officer, I attempted to obtain patient's (or representatives) written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____

Name of Privacy Officer:_____