MAURO FAMILY DENTISTRY
FINANCIAL POLICY

For the convienience of our patients, we offer several alternatives to pay for your dental services. Please read through the following choices.

For patients with an insurance company in which we are participating, preventive and basic services will be sent to your insurance company for payment to this office with co-pay due after insurance payments. For major work, estimates of insurance co-payments will be given and are due by the completion of those services.

For patients who do not have dental insurance payment plans are available for major work and these arrangements must be made in advance. We also offer interest free financing through Chase Bank.

For your convenience we do accept cash, checks, Master Card and Visa. (there will be a $30.00 charge on all returned checks)

Past due accounts will be turned over to a collection agency and all fees associated with this process will be billed to the patient. If financial arrangements have been made and payments are delinquent, this office reserves the right to reschedule any non-emergency appointments until the account is brought to a current status.

We believe that your time is valuable. As a consequence, we maintain a daily schedule and strive to adhere to it. We truly appreciate your patience at these times. We urge that you be on time for your appointments so that patients that follow you on the schedule will not be delayed. Please understand, however that emergencies do occasionally occur and may cause delays. Once an appointment has been reserved for you, we require that a minimum notice of **24 hours** be given if you will be unable to keep the appointment. This courtesy on your part will make it possible to schedule another patient waiting for treatment. **Please note that there will be a fee of $39.00 per hour for a broken or missed appointment without the minimum required notice. We also reserve the right to dismiss a patient from the practice who has missed 3 appointment times or who habitually cancels appointments.**

In an effort to make your dental care more affordable we are preferred providers of most Insurance Companies. We are **NOT** providers in any **DMO** or **HMO** plans. It is important that you understand that as your dental care provider, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility if there is a problem with the insurance payment.

We will gladly answer any questions you may have relating to your insurance. You must realize however that: 1.Not all services are a covered benefit in all contracts. 2. It is your obligation to know your contract limitations regarding specific procedures. 3.Any information our office gives regarding your insurance coverage is an estimate.

I have read, understand and agree to the above office policy. I understand that I am fully responsible for the fees of services rendered, regardless of any insurance that I may have.

SIGNATURE_____ **DATE** _____

Chart #: «Chart»
FOR OFFICE USE ONLY

Patient Information

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

Gender: _____ Family Status: _____

Social Security #: _____ **Birth Date:** _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Do You Have or Have you ever had any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/ HIV	☐	☐	Excessive Bleeding	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐
Allergies/ List_____			Fainting/ Seizures	☐	☐	Leukemia	☐	☐	Tuberculosis	☐	☐
			Glaucoma	☐	☐	Nervous Disorders	☐	☐	Tumors	☐	☐
Anemia	☐	☐	Emphysema	☐	☐	Pacemaker	☐	☐	Ulcers	☐	☐
Arthritis	☐	☐	Dizziness	☐	☐	Pregnant	☐	☐	S T D s	☐	☐
Artificial Joints	☐	☐	Heart Attack	☐	☐	Due date:_____			Stomach Problem	☐	☐
Asthma	☐	☐	Heart Disease	☐	☐	Radiation Treatment	☐	☐	M V P	☐	☐
Blood Disease	☐	☐	Heart Murmur	☐	☐	Respiratory Problems	☐	☐	Kidney Disease	☐	☐
Cancer	☐	☐	Hepatitis /Jaundice	☐	☐	Rheumatic Fever	☐	☐	Epilepsy	☐	☐
Diabetes	☐	☐	High Blood Pressure	☐	☐	Rheumatism	☐	☐	Angina	☐	☐

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you allergic to or have had a reaction to any of the following? Local Anesthetic, Sulfa, Penicillin, Iodine, Aspirin, Latex Rubber, any Metals, Other _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Are you taking any medications prescription or non-prescription? ☐ Yes ☐ No
  If yes, please list: _____

Dental History

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

Check (√) if you have had problems with any of the following:

Bad breath ☐	Grinding teeth ☐	Sensitivity to hot, cold, sweets ☐
Bleeding gums ☐	Periodontal treatment ☐	Sensitivity when biting ☐
Loose teeth or broken fillings ☐	Sores or growths in your mouth ☐	Food collection between teeth ☐
Prolonged bleeding after extraction ☐	Orthodontic treatment ☐	

How often do you brush? _____ How often do you floss? _____

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): _____ Ext: _____ Best time to call: _____

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: _____ **Social Security #:** _____ **Group #:** _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

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: _____

Whom may we thank for referring you to our practice? _____

Emergency contact _____ **phone** _____

To the best of my knowledge, all of the preceding answers and information provided are correct. If I ever have any change in my health, or insurance information I will inform the doctors at my next appointment.

_____ Date: _____

Signature of patient, parent or guardian

HIPAA Release Form

Patient Name: _____ Data of Birth: _____

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information.

This information may be released to:

☐ Spouse _____

☐ Child(ren) _____

☐ Other _____

☐ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call:

☐ my home

☐ my work

☐ my cell number: _____

If unable to reach me:

☐ you may leave a detailed message

☐ please leave a message asking me to return your call

☐ do not leave a message

_____ _____

Signature Date