dhcc
Dental Health Care Center

1717 East 66th Street
Richfield, MN 55423
612-861-7109

PATIENT INFORMATION

Name: ____ Preferred Name: _____________________

Date of Birth: ______________________ Social Security Number: ____________________ Male ☐ Female ☐
Month Day Year

Address: ____ City: ___________________ ST: _____ Zip: _______

Home Phone: ______________________ Cell Phone: ______________________ Work: ____________________

Marital Status: Married ☐ Single ☐ Minor ☐ E-Mail: ____

Emergency Contact: ____
Name Phone # Relationship

How did you learn about our practice & why did you choose us? ____

Were you referred by a family member, friend, co-worker? (please circle)

Primary Dental Benefits: ______________________ ID #: _____________________ Group #: ______________

Policy Holder Name: _____________________________________ Relationship: _________________________

Policy Holder's Social Security #: ________________________________ Policy Holder's DOB: _______________

Phone #: ________________________ Employer of Policy Holder: _____________________________________

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Secondary Dental Benefits: ___________________________ ID #: __________________________ Group #: _______________

Policy Holder Name: _____________________________ Relationship: ___________ Employer: __________________________

Policy Holder's Social Security #: ______________________ Policy Holder's DOB: _______________ Phone #: ________________

Acknowledgement of Receipt of Notice of Privacy Practices

Your May Refuse to Sign This Acknowledgement

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance to this consent before we received your revocation, and that we may decline to treat you or continue to treat you if you revoke this consent.

Print Name: ____

Signature: ____ Date: _____________

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____ Relationship: _______________

Authorization: *I agree that the dental practice may communicate with me electronically at the e-mail address listed. I am aware that there is some level of risk that third parties might be able to read unencrypted e-mails. I am responsible for providing the dental practice any updates to my e-mail address. I can withdraw my consent to electronic communications by calling: 612-861-7109.*

Authorization: *I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.*

Responsible Party Name: ____ Date: _______________

Responsible Party Signature: _____________________________________ Relationship to Patient: _________

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FINANCIAL MENU

Dental Health Care Center offers a wide range of financial options in order to pay for your dental treatment.

A. Cash Account

If you do not have insurance, payment in full is expected at the time of service. A 5% bookkeeping allowance will be given for direct payment in full by cash or check at your visit. We also accept payment by credit or debit card but no bookkeeping allowance will be given when using this form of payment.

B. Dental Benefits

DHCC participates in a variety of benefit plans and will file the necessary forms for payment, however, we assume no responsibility for payment by any third party. Your estimated patient responsibility is due at the time of service, any unpaid balances after the claims are processed are subject to a finance charge.

C. CareCredit

With fast, on-line approval, CareCredit financing can help you get the dental care you've always needed or wanted with the financing designed specifically for you. CareCredit allows you to start treatment immediately and offers deferred interest, low monthly payments, no up-front costs, no pre-payment penalties, and no annual fees.

I have read and understand the Financial Menu.

Responsible Party Name (Print): _____

Responsible Party Signature: _____ **Date:** _____

OPTIONAL

FORMS OF PAYMENT ON BALANCES DUE

If I do not pay the entire new balance within 30 days of the monthly billing date, a finance charge will be added to the account for the current monthly billing period. Unpaid balances are subject to a finance charge. A $2.00 pre-authorization will be charged to verify the card for future payments. This will show as pending on the cardholder's statement and will be reversed within 3-5 days.

We will do our best to estimate your patient responsibility, however, after your dental benefits have processed the claim for the dental services rendered at DHCC, you may have an outstanding balance. For balances owed, we ask that you leave a credit card on file. If requested, we will mail you your account receipt and transaction slip to the address on file.

Patient Name: _____

Credit Card (check one): Visa ☐ MasterCard ☐ Discover ☐ CareCredit ☐ LendingTree ☐

NOT TO EXCEED: $_____ Receipt Requested: Yes, e-mail ☐ Yes, mail ☐ No ☐

Card #: _____ Exp Date: _____ Sig. Code: _____

Card Holder Name (print): _____

Billing Address: _____ State: _____ Zip:_____

I hereby authorize Dental Health Care Center to process payments from time to time, as the office deems necessary, to settle my account in full. The agreement is considered valid until written notification is received. I certify that I have read, fully understand, and accept the above financial policy.

Card Holder Signature: _____ **Date:** _____

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GENERAL CONSENTS

Consent to Share Confidential Medical & Dental Information

To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share. I understand that if I do not fill this form completely, my information will not be shared with anyone other than those covered under the HIPAA consent to carry out treatment, payment activities and healthcare operations.

Patients Legal Name:_____ Date of Birth: _____

I HEREBY AUTHORIZE DENTAL HEALTH CARE CENTER TO SHARE:

_____ My appointment times, dates, and reasons for the visits
_____ The medications I am taking/have taken
_____ The following information (specify): _____

WITH THE FOLLOWING:

Full name:_____ Relationship: _____

Full name:_____ Relationship: _____

I understand that I may cancel this consent at any time (by writing to DHCC), but that canceling it will not affect any information that has already been released. By signing this form I agree to allow my medical/dental provider or my clinic to share information with the listed people/entities.

PHOTOGRAPHS, X-RAYS, and RECORDS

I understand that photographs, x-rays, and other records may be necessary during the course of my examination, treatment, and follow-up care. I give my permission for such items to be used for purposes of research, education, promotional materials, or publications in professional journals**.** ☐ I do not give permission for my records to be used

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COMPOSITE RESTORATIONS

At Dental Health Care Center direct placed restorations are composite resins. We believe they are the most esthetic, and function superior to amalgam (mercury/silver).
Please read the following information concerning composite restorations:

1. My direct placed restoration will be done as a bonded resin-composite unless otherwise noted.
2. My dental benefits may or may not cover the cost of this restoration, substituting payment for an amalgam restoration instead.
3. I understand that I am responsible for any difference in fee between an amalgam and composite restoration.

CANCELLATION POLICY

When we make your appointment, we are reserving a room especially for your particular needs. We ask that if you must change an appointment, please give us at least 2 BUSINESS DAYS notice. This courtesy makes it possible to give your reserved room to another patient in need. There is a $75 charge for not showing up for scheduled appointments, or for cancelling an appointment without sufficient notice. Repeat cancellations or missed appointments will result in the loss of future appointment privileges.

My signature here means I have read the above and understand the information concerning photos, x-rays, and records, composite restorations, the consent to share confidential medical and dental information, and the cancellation policy. This consent is valid until revoked in writing.

Responsible Party Name: _____

Responsible Party Signature: _____ Date: _____

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General Consent to Treatment of a Minor

Please fill out if patient is under 18 years of age

Patient Name: ____ **Date of Birth:** ____________________

I authorize Dental Health Care Center (DHCC), its dentists and members of its team, to provide such regular dental care including cleaning, x-rays, and fluoride to the minor as is necessary for the minor's health and best interests, or as in your judgment is advisable. This authorization includes but is not limited to authorization for DHCC dentists to perform specific procedures including extractions and restorative procedures. I authorize DHCC, its dentist and members or its team to act on my behalf in case the minor is a victim of major accident, injury or illness when immediate dental or surgical care is needed, provided diligent effort is made to notify me of the situation and obtain my preferences. If such efforts to contact me are unsuccessful, I authorize DHCC, its dentists or members or its team to take such action and give such consent on my behalf as their judgment dictates. I acknowledge that DHCC deems it advisable that an authorized adult accompany the minor to the clinic for examination and treatment. I agree to cooperate by being present at all times possible or when requested. If you are not the minor patient's parent, you must provide proof of legal guardianship (i.e. court order or power of attorney).

1. Responsible Party: __________________________________ Phone #: ______________________ DOB: __________

Address: ____

Relationship to Patient: ___________________

2. Responsible Party: __________________________________ Phone #: ______________________ DOB: __________

Address: ____

Relationship to Patient: ___________________

<u>Other Individuals Authorized to Consent to Treatment</u>

In addition to the legal guardians of the patient, the following persons are authorized to consent to recommended medical care for my child: name and relationship to patient.

Name:	**Relationship to Patient:**
1. ____	________________________________
2. ____	________________________________
3. ____	________________________________

My signature here means I have read this information and understand it. This consent is valid until revoked in writing.

Guardian Name: ____**Relationship to Patient:** _____________

Guardian Signature: ____ **Date:** __________________

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<u>For Office Use Only</u>

Telephone consent obtained by (Name/Date/Title): ____

Name of Interpreter & Company/Phone (if used): ____