CORAL DENTAL CARE

Modern dentistry with a gentle touch!

FINANCIAL POLICY

All patients must complete a patient registration form, a health history form and the HIPPA form before seeing the doctor or hygienist.

PAYMENTS

- ***Full payment is due at the time services are provided.***
- *For comprehensive treatment plans requiring multiple visits, Coral Dental Care requires a minimum deposit of 50% of the total patient portion of fees at the start of treatment.*
- *Patient is always responsible for any amounts not covered by insurance, regardless of whether the original estimate included an expected insurance benefit.*
- *We accept cash, checks, Visa, MasterCard and CareCredit.*

PATIENTS WITH A DENTAL PLAN

If you have dental insurance, we ask that you provide us with all of your insurance information prior to your first appointment. It is important to understand that you actual insurance benefits may differ from the benefits estimated in your Treatment Plan Estimate. Your dental plan may or may not include benefits for certain services rendered in this office.

The Treatment Plan Estimate is just that, an estimate based upon the benefit information dictated to us by your insurance carrier and in no way is a guarantee of benefits. Please understand that your dental plan is a contract between you and your insurance carrier. You, the patient, are responsible for all the services provided and any amount not covered by your insurance.

We are happy to assist you in obtaining the allowable benefits and to process the required forms at no charge despite the time necessary to do so. Claims uncollectible after three months will become the responsibility of the patient and payable in full. If you have 2 insurance policies, a primary and a secondary, we will submit to the primary first and then to the secondary after we receive a statement from the primary insurance company, this process can take between 30-90 days before full payment is received.

CO-PAYMENTS

When we collect co-payments, we are estimating your amount due at the time of service. We try to estimate as close as possible in order for you not to have any additional payment. However, sometimes our estimates leave a balance, in which case you will be responsible for the difference. It is not our intention to have you pay any more than you would owe. If by chance your insurance pays more than we anticipate, we will have no problem reimbursing you.

MAJOR SERVICES

All fees for major services will be discussed prior to treatment, but may be subject to change at the time of your appointment. Your proposed treatment plan is given to you prior to your appointment with detailed treatment explanation; your dental plan estimate and your fees due at the time services are rendered. This proposed treatment plan must be signed before any services are rendered.

FINANCIAL

- A monthly interest charge of 1.5% will be included on accounts that are overdue.
- Any expense incurred from returned checks is your responsibility and will be added to your account balance.
- You will be responsible for an additional 40% of your balance for collection fees incurred.

We encourage you to discuss any financial concerns that you may have so that we may assist you in the effective management of your account.

I have read, understand and agree to the financial policy described above.

Signature of Patient, Parent or Guardian _____ Date _____

Authorization to Release Dental Information to Family Members/Friends

Patient's Name (Print): _____Date of Birth_____

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers and primary care physicians, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with regarding your dental condition and/or dental treatment. **Spouses are not automatically included; their names must be explicitly stated below**. You may opt out by checking the "Do not Release Information" box below.

Authorization to speak with family/friend (including spouse)

I give the following named person(s) authorization to take messages or speak with Dr. Anu Isaac and staff of Coral Dental Care, on my behalf regarding all aspects concerning my dental treatment/condition and account:

- Name of authorized person(s):

_____

Relationship _____Phone #

_____

- Name of authorized person(s):

_____

Relationship _____ Phone #

_____

OR

- **DO NOT RELEASE INFORMATION TO ANYONE** _____

(Patient Initials)

Authorization to Leave Health Information by Alternate Means

I authorize Dr. Anu Isaac and staff of Coral Dental Care to use the telephone numbers provided by me to leave messages on voice mail for reminder calls and other patient matters.

I understand that my express consent is required to release any health care information. With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed above.

Signature _____ Date_____

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I have received a copy of Coral Dental Care Notice of Privacy Practices.

Print Name:_____

Signature:_____

Date:_____

For Office Use Only

_____

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

Appointment Cancellation Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If this happens, we respectfully ask that you do give us at least 48 hour notice.

Our doctor and hygienist want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, other patients lose an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to have to enforce the policy and charge for no-show appointment and those not cancelled within 48 hours. ***As of Monday June 1 , 2015 there will be a fee of $75 charged to any person who does not give 48 hour notice or no-shows for a scheduled appointment.***
Thank you for being a valued patient and for your understanding and cooperation with us as we enforce this policy.

_____
Patient name

_____ _____
Patient signature Date

Coral Dental Care

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Name of Primary Care Physician _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: Have you ever had MRSA? ◯ **Yes** ◯ **No**

Do you take any medication, pill, vitamin, or supplement for bone density? ◯ **Yes** ◯ **No**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Email Address _____

Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of the form.

1. **Treatment to be Provided**

I understand that during my course of treatment that the following care may be provided:
Examinations _____ Preventative Services _____ Restorations _____
Crowns _____ Bridges_____ Other _____ **Patient Initials** _____

2. **Drugs and Medications**

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). **Patient Initials** _____

3. **Changes in Treatment Plan**

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary. **Patient Initials** _____

4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. **Patient Initials** _____

_____ _____

Patient Signature Date