IMPORTANT INFORMATION FOR OUR PATIENTS

TERMS OF PAYMENT:
The following is a guide to the terms of payment we accept. We are committed to working with you to match a payment plan to your needs; therefore, we offer different options to our patients, which allows for payment to be convenient and flexible. We are available to answer any questions you may have at any point.

DENTAL INSURANCE:
We will gladly assist you with your dental insurance plan. To help us assist you in determining your maximum benefit, please bring your insurance card to every visit. Most plans cover only a portion of the dental fee; therefore, as a courtesy to our patients we will file your primary insurance for you, and we ask that you pay the non-covered balance at the time of service unless prior arrangements have been made. If your insurance company has not paid within 30 days, you will be billed for the unpaid balance and payment in full will be expected at this time. We recommend you become directly involved in communication with your insurance company to expedite payment.

PAYMENT OPTIONS:
We accept Visa, Mastercard, American Express, Discover, money order, cash, CareCredit, personal check or Lineberger Dentistry Savings Plan.

APPOINTMENTS:
In order to allow the best possible care for our patients, we reserve a specific time for you and make every effort to see you as scheduled. We appreciate your promptness and consideration in not changing your scheduled appointment. If cancellation is necessary, a minimum of 24- hour notice is required. A fee may be applied for appointments missed or cancelled within 24 hours.

SIGNATURE OF RESPONSIBLE PARTY DATE

LINEBERGER DENTISTRY

Today's Date: _____

## *Patient Information:*

Last Name: _____

First Name: _____ MI: ____

Date of Birth: _____ Age: ____

Gender: _____ Marital Status: _____

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer/ School Name: _____

Occupation: _____

Phone (Home): _____ (Cell): _____

(Work): _____ Ext: _____

Email: _____

Spouse's Name: _____

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

_____

**How did you hear about us?**

_____

**In case of an emergency, contact:**

Name: _____ Phone: _____

Relationship: _____

## *Insurance Information:*

Name: _____

Birth Date: _____ ID/SSN: _____

Group #: _____ Employer Name: _____

Relationship to Patient: _____

Address: _____

Insurance Plan Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

**Secondary Insured's Information**

Name:

Birth Date: _____ ID/SSN: _____

Group #: _____ Employer Name: _____

Relationship to Patient: _____

Insurance Plan Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

## Responsible Party Information

Person Responsible for Account: (Print Name) _____

I accept responsibility for payment of all dental services rendered in this office for myself and my dependents regardless of what insurance benefits may apply. Payment is due at the time of service and I understand that financial arrangements MUST be made prior to dental appointments. Assignment of insurance benefits, if applicable, is a courtesy extended to me and does not replace my responsibility for all charges incurred. Your signature will also allow us by law to prepare your insurance forms and assist in making collections from insurance companies to credit your account.

**Patient/Responsilbe Party: (Signature):** _____ **Date:** _____

### HITECH ACT

The federal Red Flag Law requires all healthcare practices to obtain, verify, and record information that identifies every patient (new & existing). A digital photo will be taken at your appointment to be used as a permanent record of your identity.

# HEALTH HISTORY

*Do you have or have you ever had any of the following? Please circle YES or NO*

| | | |
|---|---|---|
| Y N AIDS/HIV | Y N Thyroid Disease | Y N Osteoporosis |
| Y N Alzheimer's Disease | Y N Blood Disease | Y N Respiratory Problems |
| Y N Psychiatric Care | Y N Blood Pressure | Y N Asthma |
| Y N Are you pregnant | High or Low | Y N Tuberculosis |
| Due Date _____ | Y N Blood Thinners | Y N Herpes |
| Y N Artificial Joints | Y N Blood Transfusion | Y N Ulcers |
| Y N Artificial Heart Valve | Y N Prolonged Bleeding | Y N Drug Dependency |
| Y N Congenital Heart Defects | Y N Hepatitis | Y N Sensitivity to |
| Y N Previous Infective | Type A/B/C | Epinephrine |
| Endocarditis | Y N Anemia | Y N Allergy: Penicillin |
| Y N Pacemaker | Y N Sickle Cell Anemia | Y N Allergy: Latex |
| Y N Cancer | Y N Diabetes | Y N Allergy: Sulfa Drugs |
| Y N Chemotherapy | Type: I or II | Y N Allergy: Ibuprofen |
| Y N Radiation Therapy | Y N Liver Disease | Y N Allergy: Aspirin |
| Y N Epilepsy/Seizures | Y N Jaundice | Y N Allergy: Codeine |
| Y N Fainting | Y N Kidney Disease | Other Allergies: _____ |
| Y N Stroke | Y N Lung Disease | _____ |

**PLEASE LIST CURRENT MEDICATIONS YOU ARE TAKING:** (*Attach list for additional medications*)

_____

_____

Y N Do you smoke or chew tobacco? (Type and how much): _____

Y N Have you ever had any complications following dental treatment? Explain: _____

Y N Have you been admitted to a hospital or needed emergency care during the past two years: Explain: _____

Y N Are you currently under the care of a physician? Explain: _____
Name of Physician: _____ Phone Number: _____

Y N Have you ever used a bisphosphonate medication? Common brands are Fosamax, Actonel, Atelvia, Didronel and Boniva.

Y N Do you have any health problems that need further clarification? Explain: _____

## *Dental History*

Reason for today's visit: _____

Name of previous Dentist: _____ Date of last dental visit: _____ Date of last x-rays: _____

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

Y N Do your gums bleed when you brush? _____

Y N Have you ever been treated for periodontal disease (deep cleaning, bone grafting, etc.)? _____

Y N Do you have pain when chewing? _____

Y N Do you grind or clench your teeth? _____

Y N Do you have a biteguard? _____

Y N Do you have any loose or cracked teeth? Where? _____

Y N Do you have any missing teeth? Where? _____ Replaced? _____

Y N Have you ever had a cold sore/ fever blisters? How often? _____

Y N Have you ever had orthodontic treatment? If yes, when? _____ Doctor's Name: _____

What would you like to change about your smile? _____

# NOTICE OF PRIVACY PRACTICES

The dental practice of Dr. Adrian S. Lineberger has a Legal Duty to:

Keep your personal health information private

1. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information
2. Follow the terms of the current notice
3. Notify you in a timely manner of an accidental disclosure of your private health information

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices: When we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

## USE AND DISCLOSURE OF YOUR PRIVATE HEALTH INFORMATION

The following describes different ways that we use and disclose your private health information. Not every use or disclosure is listed. However, we have listed all the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical or dental information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

1. We may use your PHI to provide you with dental treatment or services. We may disclose medical information about you to healthcare providers who may be involved in your treatment both directly and indirectly.

2. We may use and disclose your PHI for payment purposes. A bill may be sent to you, a third-party payer or to a collection agency. The information on or accompanying the bill may include your treatment information.

3. We will not sell or use your personal health information for marketing or fundraising purposes without first obtaining your signed authorization.

4. We are required to inform you if there are any financial conflicts of interest with us and the products or services utilized by us.

5. If you pay for your dental treatment and request that we not disclose the procedure to your insurance company we must comply with your request as long as you pay in full for the procedure in a timely manner.

6. You have the right to request a copy of your health records and to request the type of format you want (paper or electronic). If you request, in writing, that a copy of your records be sent to a specific third party, we are required to send them as directed and in a timely manner.

## PATIENT ACKNOWLEDGEMENT

I understand that I may request in writing that you restrict how my private health information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENT/GUARDIAN NAME: (PRINT)_____

RELATIONSHIP TO PATIENT:_____

SIGNATURE: _____ DATE: _____