



PATIENT INFORMATION

Date: Patient: NEW PATIENT UPDATE
LAST FIRST MI PREFERRED TITLE
MALE FEMALE CHILD* STUDENT** SINGLE MARRIED DIVORCED WIDOWED
*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW: **IF STUDENT, PLEASE COMPLETE: FULL-TIME PART-TIME
PARENT/GUARDIAN NAME(S) SCHOOL/LOCATION
Patient Date of Birth: Patient SSN:
Address: ADDRESS LINE 1 ADDRESS LINE 2 CITY ST ZIP CODE
E-Mail: HOME: CELL: OTHER: PAGER: FAX:
Referral? Yes No Referred by:

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:
NAME RELATIONSHIP Tel:

EMPLOYMENT INFORMATION

Employer: Occupation:
Address: ADDRESS LINE 1 ADDRESS LINE 2 CITY ST ZIP CODE
E-Mail: WORK: DIRECT: OTHER: PAGER: FAX:

INSURANCE INFORMATION

Subscriber: LAST FIRST MI PREFERRED TITLE
Subscriber Date of Birth: Subscriber SSN:
Subscriber Employer:
Patient Relationship to Subscriber: SELF SPOUSE CHILD OTHER
PRIMARY INSURANCE CARRIER:
Group/Policy No.: ID No.:
Address: TEL: TOLL-FREE: FAX:
CITY ST ZIP CODE
SECONDARY INSURANCE CARRIER:
Group/Policy No.: ID No.:
Address: TEL: TOLL-FREE: FAX:
CITY ST ZIP CODE



CHERYL HOFFMAN, DDS
THOMAS HOFFMAN, DDS

INTEGRITY • FAMILY • COMPREHENSIVE DENTISTRY

WWW.HOFFMANDENTALOFFICE.COM

Tel: 614-451-4400

1600 FISHINGER RD.
UPPER ARLINGTON, OH 43221

PREVIOUS DENTIST INFORMATION

Dentist: Telephone:
Clinic/Facility:
Address:
CITY ST ZIP CODE
Reason for changing:

DENTAL HISTORY

ORAL HEALTH: EXCELLENT GOOD FAIR POOR
Date of Last Dental Visit: Treatment Type:

Are you currently having dental discomfort? If yes, explain:
Any unhappy/unpleasant dental experiences? If yes, explain:
Any injuries to mouth/teeth/head? If yes, explain:
Any missing teeth other than wisdom teeth or orthodontic extractions?
Have missing teeth been replaced?
Orthodontic appliances now or in the past?
Gums bleed when brushing or flossing?
Concerned about gum disease? History of gum disease?
Any concerns about the appearance of your teeth?
Does it hurt to bite or chew?
Do you clench or grind your teeth? If so, do you wear a night guard or splint?
Do you want your mouth properly restored and pain free?
Does any type of dental treatment make you nervous? If yes, please explain below:

The most important concerns regarding my dental treatment are:

What factors are most important for your satisfaction with our office?

Any additional concerns/comments?

CHILD/MINOR PATIENTS: PLEASE ANSWER THE FOLLOWING QUESTIONS:

Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.)
Any unusual speech habits? If yes, explain:
Any lost teeth? If yes, list:
Does the patient receive assistance with brushing and flossing? If yes, how often?

PRIMARY PHYSICIAN INFORMATION

Physician: Telephone:
Clinic/Facility:

Financial Guidelines

We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

Insurance

We accept all major dental insurance plans; however, we may not be a contracted provider for your plan. If we are not a contracted provider, review your plan details, as in many cases insurance reimbursement is very similar. Your insurance is a contract between You, Your Employer and the Insurance Company. Please remember that our relationship is with YOU! Your insurance is meant to reimburse the dentist for services retained by you, the patient.

- We are **contracted** with Delta Dental Premier and Aetna Extend.
- **No estimate is a guarantee of payment.** Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.
- Some specialized services, including but not limited to, cosmetic procedures, orthodontic procedures, and porcelain restorations, incur additional fees associated with the fabrication of such items. These fees are not billable to dental insurance and are the responsibility of the patient. All fees will be presented ahead of time if applicable.

Payments

- **For some treatments, a deposit of 15% may be required when scheduling. Remaining patient co-pays** are due at the time services are rendered unless prior arrangements have been made.
- **Payment Information:**
 - o All major credit cards are accepted (Visa, MasterCard, Discover and American Express)
 - o Various payment options are available to all patients. Including financing options with CareCredit® and LendingPoint. Speak with your Treatment Coordinator for more details.
- **Balances left over 60 days will incur a \$25 minimum monthly finance charge. We realize that temporary** financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.
- **Minors must be accompanied by a parent or legal guardian.** If the parents are separated or divorced, the person accompanying the minor will be responsible for copayment at the time of service.

Short Cancelled/ Missed Appointments/Miscellaneous Fee's

- **In respect for all our patients, we kindly request 2 business days in advance notice to change an appointment.**

- We reserve the right to charge a fee for missed appointments and/or appointments cancelled/rescheduled without adequate notice.

By signing below I acknowledge I have read and understand the guidelines above.

Signature:

Date:



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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2013

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

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

Signature:

Date:

RELATIONSHIP TO PATIENT: ADULT PATIENT PARENT GUARDIAN OTHER

Please list any dependent children under the age of 18 also covered by this acknowledgement:

I give permission for the following communications to be used by Hoffman Dental (please check all that apply) :

- Cell phone: Text Message reminders permitted
- Home phone Work E-Mail:

I am granting permission for Hoffman Dental to disclose their identity to anyone who may answer my home, work or cell phone.

I am granting permission for Hoffman Dental to leave a message with any person who may answer my phone or on my voicemail of the following numbers (please check all that apply):

- Home Phone Cell Phone Work Phone None- please just ask for a call back
- Other (Please explain)

I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above:

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other – please list:



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To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

I hereby authorize payment directly to Hoffman Dental of the dental benefits otherwise payable to me.

I hereby authorize Hoffman Dental to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental claims and/or discussing treatment options with other dental professionals.

I hereby give my consent for Hoffman Dental to treat me and/or my family for our dental needs.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature:

Date: