MONROVIA
FAMILY DENTISTRY

Appointment Cancellation Policy

Monrovia Family Dentistry has implemented appointment reminder and confirmation systems that utilize emails and cell phone text messages, as well as personal phone calls, to remind you and your family members of upcoming appointments with our office. It is our pleasure to provide these services to our patients at NO CHARGE as a means to better enhance your patient experience.

If you are ever unable to keep a scheduled appointment with our dental office, we require at least a two (2) business days notice by calling our office to reschedule or cancel your appointment. If your notice is not received within the two (2) day window, a short-notice fee may be charged to your account.

Patient Financial Responsibility

As a condition of your treatment by this office, I understand that payment in full is due at the time services are rendered. I may pay with cash, personal check, credit or debit card, or CareCredit. I understand that all emergency dental services or any service performed after regular business hours must be paid at the time services are rendered.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all delinquent accounts, starting on the date the debt was incurred.

I consent and understand that any fee estimate or insurance estimate given to me as part of my treatment plan fees is only an estimate, and due to the nature of dental care and unforeseen problems or changes that may arise during treatment, fees and/or treatment may also change as a result.

In the event that my account becomes delinquent, I understand that future treatment may be delayed until the balance has been paid. I also understand that if my account becomes delinquent, I shall be solely responsible for any and all collection fees, attorney fees, court costs, interest charges, and any other reasonable fee or charge as a result of my delinquent account.

If I choose Assignment of Benefits with regards to my insurance plan reimbursements, I authorize payment of dental benefits, otherwise payable to me, directly paid to Monrovia Family Dentistry. I also grant my permission to you or your assignee, to telephone me at home or work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

_____ _____ / _____ / _____

Signature of Patient *Date*

_____

Printed Name

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
The practice reserves the right to change the privacy policy as allowed by law.
The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
The practice may condition receipt of treatment upon execution of this consent.

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Emergency Contact: _____

Phone Number: _____

TIME 02:45 PM DATE 1/5/2021

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Emergency Contact

Emergency Contact #

Referred by:

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Monrovia Family Dentistry

Patient Name: Birth Date: Date Created:

General Health Problems? If so, Please Explain:	◯ Yes ◯ No	If yes	
Have you ever been hospitalized or had a major operation? If so, Please Explain:	◯ Yes ◯ No	If yes	
Do you use tobacco? If so, Please Explain:	◯ Yes ◯ No	If yes	
Are you taking any medications, pills, or drugs? If so, Please List:	◯ Yes ◯ No	If yes	
Currently seeing a Doctor? If so, Please Explain and List Physician Name _Phone #:	◯ Yes ◯ No	If yes	
Heart Attack, or other Heart Ailments? If so, Please Explain:	◯ Yes ◯ No	If yes	
Stroke? If so, Please Explain:	◯ Yes ◯ No	If yes	
Valve Replacement or Unexplained Congenital Heart Defects? If so, Please Explain:	◯ Yes ◯ No	If yes	
Prolonged Bleeding or Healing Complications? If so, Please Explain:	◯ Yes ◯ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or other bisphosphonates? If so, Please Explain:	◯ Yes ◯ No	If yes	
Taking a Blood Thinner - PLavix, Coumadin, or Warfarin? If so, Please List:	◯ Yes ◯ No	If yes	
Taking a Beta Blocker for High Blood Pressure Metropolol or Antenolol? If yes, Please List:	◯ Yes ◯ No	If yes	
Any Joints Replaced? If so, Please Explain:	◯ Yes ◯ No	If yes	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

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

Other? ☐ If yes

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

HIV or Hepatitis Positive	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No
Epilepsy or Seizures	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	History of Bacterial Endocarditis	◯ Yes ◯ No

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

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:

X Date:_____