Joplin Periodontics & Implant Dentistry
Humaira Y. Habib, D.D.S.

Today's Date:
Preferred Name:

Patient Information

Last Name: First: Middle:	Mr. Mrs. Miss. Ms.	Birth Date: / /

Is that your legal name? Yes or No	If not, what is your legal name?	Age:	Sex: Male or Female

Address:	City/State:	Zip:

SSN:	Cell:	Emergency Contact:	Email:

Occupation:	Employer:

Whom may we thank for referring you?

Pharmacy Name, City and State (All medication will be sent to this pharmacy unless otherwise communicated)

Guardian or Responsible Party

Relationship to Patient: Self Spouse Parent Other	Full Name:	
Address:	City/State:	Zip:
Employer:	Date of birth:	SSN:

Dental Insurance

Please provide insurance cards when possible

Primary Insurance:	**Subscriber's Full Name:**	
ID# OR SSN:	**Birth Date:**	**Group #:**
Patient's relationship to subscriber: Self Spouse Child Other_____		**Employer:**

Secondary Insurance:	**Subscriber's Full Name:**	
ID# OR SSN:	**Birth Date:**	**Group #:**
Patient's relationship to subscriber: Self Spouse Child Other_____		**Employer:**

*****Medical Insurance, Medicare and Medicaid Disclosure*****

Joplin Periodontics does not file to Medical Insurance of any kind. However, the staff can provide you with all records and dental codes needed for the patient or responsible party to file their own medical insurance claim.

Joplin Periodontics is not a contracted provider for Medicare or Medicaid therefore all services rendered or planned treatment is to be paid by the patient or responsible party.

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Patient Health History

Medical Conditions:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves(s)
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Blood Thinner
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Lesions
- ☐ Contact Lenses
- ☐ Cortisone Treatments
- ☐ Cough, Persistent or Bloody
- ☐ None
- ☐ Diabetes
- ☐ Dementia
- ☐ Diet(Special/Restricted
- ☐ Dizziness/ Fainting
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding/Bruising
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Murmurs
- ☐ Heart Problems
- ☐ Hepatitis A/B
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Jaw Popping/Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pace Maker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sinus Problems
- ☐ Skin Rash
- ☐ Stomach Problems/Ulcer
- ☐ Stroke
- ☐ Swollen Feet/Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tobacco use
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Venereal Disease
- ☐ X-rays/Cobalt Disease
- ☐ Alzheimer's
- ☐ Anaphylaxis
- ☐ Cortisone Meds
- ☐ Drug problem
- ☐ Easily Winded
- ☐ Hemophilia
- ☐ Hives/rash
- ☐ Hypoglycemia
- ☐ Leukemia
- ☐ Lung Disease
- ☐ Parathyroid Disease
- ☐ Renal Dialysis
- ☐ Shingles
- ☐ Sickle Cell
- ☐ Spina Bifida

Have you ever had any serious illness not listed above? If so, explain:

Weight/Height:	Are you under a physician's care currently? Yes or No	Name/Number:
Have you ever been hospitalized?	Explain:	
Have you ever had a serious head or neck injury?	Do you use tobacco products?	If so, what type? Vape Cigarettes Pipe Snuff Chewing
Total years of tobacco use:	How much per day?	Recreational Drugs: Yes or No

If yes, please list type and frequency:

Do you need a pre-medication prior to a dental appointment? You will only need if you have any artificial joints/heart valve. Yes or No	If yes, what type of antibiotic, how many MG's, and how many pills?

Women: Are you: Pregnant Trying to get pregnant Taking oral contraceptives Nursing

Allergies: Are you allergic to or have you had any adverse reactions to the following; listed in the boxes below NONE

Antibiotics:

- ☐ Amoxicillin
- ☐ Cephalexin
- ☐ Erythromycin
- ☐ Keflex
- ☐ Penicillin

Other Drugs:

- ☐ Acetaminophen
- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Hydrocodone
- ☐ Ibuprofen
- ☐ Iodine
- ☐ Local Anesthetics
- ☐ Sulfa

Other Allergies:

- ☐ Latex
- ☐ Metals (nickel, mercury, etc.)
- ☐ Acrylic
- ☐ Nuts

Bisphosphonates:

Have you ever taken Actonel, Fosamax, Boniva or any other medications for osteoporosis? Yes or No

How long was it taken?

Date Started?

Date Finished?

<u>This type of medication can affect your healing.</u>

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Prescription Medications:	Dosage/Frequency:	Non-Prescription

******I hereby affirm that the above information is correct to the best of my knowledge. 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. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Joplin Periodontics or insurance company to release any information required to process my claims.**

Patient/ Guardian Signature : _____

Date: _____

Name of pharmacy you would like medications sent to:_____

City_____ State:_____

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Financial Policy

The following information describes our financial policy and scheduling requirements. Our primary goal is that you receive the optimal treatment needed to restore and maintain your dental health. Therefore, if you have any questions or concerns about our financial policies, please do not hesitate to ask one of our staff members.

PAYMENT:

_____1. (Initials) Payments for services rendered are due at scheduling or 1 week prior to treatment if paying in full. If using your HAS or Flex you may be asked for the card information in advance however the card will not be ran until day of service. For your convenience, we accept cash, personal checks, Visa, MasterCard, Discover and American Express. We can also provide you with the information for **Care Credit** or **Green Sky** (a convenient deferred interest credit option and low interest credit options).

_____2. (Initials) **When scheduling surgical treatment, a minimum deposit of $200** (greater if multiple implants are planned), is to be paid at time of scheduling appointment and remainder to be paid before services are rendered. Any special arrangements for payment must be made prior to treatment. All financial arrangements must be set up 1 week prior to any scheduled procedure. **If full payment has not been received within 90 days and payment arrangements have not been made /fulfilled per signed agreements, the account may be turned to collections.**

_____3.(Initials**) I agree to pay all costs of collection, including, but not limited to attorney fees and court costs.**

_____4. I certify that I have read and understand the above information to the best of my knowledge and **I understand it is my responsibility to update any changes.**

DENTAL INSURANCE:

1. As a courtesy, we will gladly submit your dental claim to your insurance company, however; you will be required to pay all accrued expenses for services rendered and/or scheduled treatment.
2. Dental plans are designed to share in the cost of your dental care, not completely pay for those costs. The amount your plan pays is determined by the selected plan agreement with the insurance carrier.
3. Our office can send a predetermination of benefits for planned services. **It is your responsibility to know your plans annual max, deductible, and used amount.**

4. Your insurance carrier makes the final payment decision on each claim for treatment.
_____ (Initials) I agree to pay for services at the time of my visit. Insurance will be sent a claim for services rendered on the date of service. **Insurance will then reimburse me or the subscriber directly** according to my plan benefits.
a. I authorize the dentist to release any information to my insurance company to process my claim and authorize payment to this doctor's office of the benefits payable on my behalf. However, in most cases insurance will send claim benefit checks directly to the subscriber
b. **Payment arrangements are to be made one week prior to all surgical appointments regardless of any Prior Authorization estimates given by insurance.**
c. Insurance benefit payments generally take 60-90 days to process and up to 120 days on more complicated claims. Having a Prior Authorization from your insurance will help the claims process to get you paid faster.

5._____**I certify that I have read and understand the above information to the best of my knowledge and I understand it is my responsibility to update any changes.**

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Scheduling Agreement

This is a time reserved just for you. Please be prompt so that we can perform all treatment that has been scheduled. **If you must reschedule**, **we request that you allow 3 full business days for hygiene appointments and 5 full business days for surgical appointments.** This policy allows our office to provide timely service to all of our patients that need treatment. **A $40 cancellation fee will apply if hygiene cancellations are not given in a timely manner**. If a patient does not call to cancel or reschedule, regarding their dental appointment, it is likely the patient may not be eligible to reschedule for a future appointment. **Cancellations must be made via phone call only.**

For any surgical treatment to be scheduled: a non-refundable $200 fee will be held. This may be forfeited if the appointment is not rescheduled 5 full business days prior to the surgical appointment.

HIPAA RELEASE OF INFORMATION

I, _____, authorize the release of information for Dental records including the diagnosis, all records on file, examination, treatment rendered to above patient, ledger/ billing, and claims information.

This information may be released to persons listed below

1. Name: _____ DOB:_____ 2. Name:_____

DOB:_____ 3.Name: _____ DOB:_____

Information is not to be released to anyone outside or referring provider. (initial here) _____

In further consideration for this, Joplin Periodontics agrees to the same stipulations. This Release of Information will remain in effect until terminating by me or filing a new Hippa form.

Messages and communication from our office

If we are unable to speak directly to you concerning matters pertaining to your care, please check one of the following preferences:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

Text Communication with Joplin Periodontics for appointment reminders, set up financials, medication was sent to your pharmacy. Would you like to opt into text message reminders?

[ ] Yes. I would like reminders via text message **[ ] No. I would not like reminders via text**

The best phone number to reach me at is: _____

Sign: _____ **Date:** _____

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Acknowledgment of Receipts of Notice of Privacy Practices
**** You may refuse to sign this acknowledgement ****

I _____, have received and/ have been offered a copy of this office's Notice of Privacy practices and understand I may request to receive a copy of Privacy Practices at any time.

Print Name: _____

Signature: _____

Today's date:_____

[ ] I do not wish to sign the Notice of Privacy Practices

- **Notice of Privacy Practices (HIPAA):** I am aware of my rights to privacy of personal health information under the Privacy Practices were made available to me in writing upon request.

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 acknowledgment
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)_____