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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PURPOSE OF CONSENT
By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

NOTICE OF PRIVACY PRACTICES
You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. This notice is posted through binder format in the reception area. A written copy in English is available. You have the right to receive this notice upon request.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Date _____ _____
Signature of person completing form

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Relationship to Patient:_____

Child's Name:_____

REVOCATION OF CONSENT
I revoke my Consent for your use and disclosure of your protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Date _____ _____
Signature of person completing form

Dan Eisenberg, DDS
Policy Of Payment For Dental Services

We are committed to providing you with the best possible care. If you have dental insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

As a courtesy to you, we will fill your insurance claims. You must realize that all charges are your responsibility from the date the services are rendered. Due to the ever changing health insurance laws and regulations, we cannot guarantee that services rendered are covered by your insurance policy. In the event that your insurance does not cover our services, you will be responsible for payment. We accept cash, checks, Visa and Mastercard. We can also assist you with applying for Care Credit Financing.

At your initial visit, you must disclose all information regarding insurance coverage that you plan to use at this office. You are also responsible for informing us of any changes to your insurance coverage. We do not work with certain insurance companies/plans. If, after treatment is initiated and any secondary policy is brought to our attention, you may have voided your right to utilize that insurance per our "no-use insurance agreement."

Charges not paid within 60 days by your insurance company will be made "patient responsibility." In the event of non-payment, you will be responsible for the cost of collections, court costs and any reasonable legal fees should these be required. Returned checks will result in a $25.00 penalty. **Account balances over 30 days past due will start to accumulate inters charges of 24% APR. This applies to all overdue account balances.**

We reserve the right to charge for appointments broken or cancelled without **48 hours** notice at a rate of **$25-50 per half hour**.

Any procedures started, such as crowns, bridges, dentures and root canals require the patient to return to finish treatment in a timely manner (6 weeks). If the patient fails to return to finish treatment within this time period and if the tooth fails or appliance does not fit, **no refund will be given up.** Patient will be responsible for any insurance company refunds and a remake charge may be assessed.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. **We are here to help you.** Please sign below to indicate that you have read and understand our policy of payment for dental services.

Printed patient/Guardian name Signature Date

Welcome!

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

Patient Information

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____ Home Phone _____
Last Name First Name Initial

Address _____ Cell Phone _____

City _____ State _____ Zip _____ E-mail _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Additional Insurance

Insured Name _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Dental History

Former Dentist _____ Date of Last X-Rays _____

City, State _____ How Often Do You Floss? _____

Date of Last Dental Visit _____ How Often Do You Brush? _____

Please check all that apply:

Bad Breath ☐	Loose Teeth or Broken Fillings ☐	Sensitivity to Sweets ☐
Bleeding Gums ☐	Orthodontic Treatment ☐	Sensitivity When Biting ☐
Blisters on Lips or Mouth ☐	Pain Around Ear ☐	Frequent Headaches ☐
Finger Nail Biting ☐	Periodontal Treatment ☐	Jaw, Head or Neck Injuries ☐
Grinding Teeth ☐	Sensitivity to Cold ☐	Jaw Difficulty: Clicking and/or Pain ☐
Lip or Cheek Biting ☐	Sensitivity to Heat ☐	Tooth Pain ☐

Medical History

Physician's Name _____ Date of Last Visit _____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Are you currently taking any medication?	☐	☐
Please describe: _____		
4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Do you wear contact lenses?	☐	☐

7. Have you had any allergic reactions to the following:

	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. (Women Only) Are You:

Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

AIDS ☐	Emphysema ☐	Pacemaker ☐
Anemia ☐	Epilepsy ☐	Psychiatric Care ☐
Arthritis, Rheumatism ☐	Fainting or Dizziness ☐	Radiation Treatment ☐
Artificial Heart Valves ☐	Glaucoma ☐	Respiratory Disease ☐
Artificial Joints ☐	Headaches ☐	Rheumatic Fever ☐
Asthma ☐	Heart Murmur ☐	Scarlet Fever ☐
Back Problems ☐	Heart Problems ☐	Shortness of Breath ☐
Bleeding abnormally, with extractions or surgery ☐	Hepatitis-Type _____ ☐	Sinus Trouble ☐
	Herpes ☐	Skin Rash ☐
Blood Disease ☐	High Blood Pressure ☐	Stroke ☐
Cancer ☐	HIV Positive ☐	Swelling of Feet/Ankles ☐
Chemical Dependency ☐	Jaundice ☐	Swollen Neck Glands ☐
Chemotherapy ☐	Jaw Pain ☐	Thyroid Problems ☐
Chronic Fatigue Syndrome ☐	Kidney Disease ☐	Tonsillitis ☐
Circulatory Problems ☐	Latex Sensitivity ☐	Tuberculosis ☐
Congenital Heart Lesions ☐	Liver Disease ☐	Tumor or growth on head/neck ☐
Cortisone Treatments ☐	Low Blood Pressure ☐	Ulcer ☐
Cough - persistent or bloody ☐	Mitral Valve Prolapse ☐	Venereal Disease ☐
Diabetes ☐	Nervous Problems ☐	

Assignment and Release

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____