BRIAN C. GNIADEK, D.D.S, LTD

Welcome To Our Office!

In order to serve you properly we will need the following information. (Please print). All information will be strictly confidential.

DATE_____

PATIENT (Ms.) (Mr.) (Mrs.) (Dr.)_____
Last First M.I. NICKNAME

ADDRESS_____
(If P.O. BOX GIVE STREET ALSO)

CITY_____STATE_____ZIP_____

HOME PHONE_____WORK_____EXT_____

CELL PHONE_____E-MAIL_____SEX M F

DATE OF BIRTH_____SOCIAL SECURITY NUMBER_____

EMPLOYER'S NAME_____NAME OF SPOUSE_____

EMPLOYER'S ADDRESS_____PHYSICIAN_____

IN CASE OF AN EMERGENCY, CONTACT (Speciy someone who does not live in your household.)

NAME_____RELATIONSHIP_____

HOME PHONE_____ WORK PHONE_____

WHO MAY WE THANK FOR REFERRING YOU?_____

BILLING INFORMATION (IF DIFFERENT FROM ABOVE)

NAME OF RESPOSIBLE PARTY_____SEX M F

ADDRESS_____RELATIONSHIP TO PATIENT_____

HOME PHONE_____WORK PHONE_____EXT_____

EMPLOYER'S NAME_____SSN_____

PAYMENT FOR OFFICE VISITS ARE DUE AT THE TIME OF TREATMENT. HOW DO YOU PLAN TO PAY FOR YOUR PORTION OF DENTAL TREATMENT? WE WOULD BE HAPPY TO ANSWER ANY QUESTIONS YOU HAVE. WE ACCEPT THE FOLLOWING.

CASH CHECK MASTERCARD VISA CARECREDIT

DO YOU HAVE DENTAL INSURANCE: NO OR IF YES, NAME OF INSURANNCE CO._____

PLEASE FURNISH INSURANCE INFORMATION .

NAME OF SUBSCRIBER_____ID#_____

DATE OF BIRTH_____SS#_____

EMPLOYER OF INSURED_____GROUP#_____

PLEASE, let us know how you are feeling today!

HAPPY ANXIOUS DISCOMFORT SEVERE PAIN

What is the reason for your visit today?_____

_____

PLEASE FILL OUT REVERSE SIDE ALSO (OVER)

MEDICAL HISTORY

Please circle any of the following which may apply to you now or in the past: **None**

Tuberculosis	Heart Failure	Angina Pectoria	Sinus Trouble	Liver Disease
High Blood Pressure	Heart Disease or Attack	Allergies or Hives	Yellow Jaundice	Bleeding Problems
Diabetes	Artificial Heart Valve	Heart Pace Maker	Drug Addiction	Anemia
Ulcers	Rheumatic Fever	Congenital Heart Lesions	Thyroid Disease	Artifical Joint
Systemic Bacteremia	Mitral Valve Prolapse	Hepatitis A (infectious)	Pain in Jaw Joints	Fainting or Dizzy Spells
Fungal Infection	Heart Murmur	Hepatitis B (serum)	AIDS	Bruise Easily
Glaucoma	Heart Surgery	Hepatitis C	HIV Positive	Epilepsy or Seizures

Any other diseases or problems?_____

PHARMACY_____**LOCATION**_____

WOMEN: Are you pregnant?_____**If so, what month?**_____

Have you ever had an unusual reaction to an anesthetic or drug such as Penicillin, Erythromycin, Novacaine, Codeine, Asprin, ETC.? YES_____**NO**_____ **If yes, please explain**_____

List any allergies:_____

_____

Medications taking at present:_____

_____

Have you taken Asprin or Ibuprofen in the last 72 hours? **YES** **NO** **Asprin** **Ibuprofen**

Aproximately how many?_____

Legal Assingment of Benefits and Financial Agreement

I understand I am financially responsible for all services and fees incurred.

DATE_____**SIGNATURE**_____
(patient, or parent/guardian of minor patient)

I herby authorize my insurance benefits to be paid directly and I also authorize the Doctor to release any information required to process insurance claims

DATE_____**SIGNATURE**_____
(patient, or parent/guardian of minor patient)

Office Policies/Dental Insurance/Private Pay

We are committed to providing you with the best possible care that's why we always try to present you with the best dental solution possible to treat your personal situation. Here are some important things you should know about receiving care at our office:

(Please Initial):

____ A specific amount of time is reserved especially for you, and we strongly encourage all patients to keep their appointments. If you must change your appointment, we **require at least 48 hour notice** to avoid a **$50/hour cancellation fee** (emergencies are an exception). **$100.00 fee for a missed Saturday appointment**.

____ Balances older than **60 days** will be subject to a **monthly $25.00 late fee** until the account balance is brought current.

____ Dr. Gniadek does require payment in full for your portion, including deductible and co-payment at the time your services are rendered unless payment arrangements have been approved in advance by our staff**. We accept cash, check, MasterCard, Visa, and Discover**.

____ Your dental benefits are based upon a contract between your employer and an insurance company. **If you have any questions regarding your dental benefits, please contact your employer or insurance company directly**.

____ We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list, or require our office to accept a reduced fee for service). However, **we may or may not be an in-network provider for your insurance**. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you an absolutely accurate quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ***ONLY AN ESTIMATE***. (If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment, but will give you a better idea of out-of-pocket expenses).

____ We will bill your insurance company as a courtesy. **If insurance does not pay within 90 days, Dr. Gniadek reserves the right to request payment in full for services from you**, and let you collect the insurance funds that are due you. This is rare, but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately you are responsible for all charges incurred in our office.

____ In the event of an emergency during regular business hours, a $68.00 emergency fee will be charged in addition to the necessary treatment fees. Established patients will be charged a $150.00 emergency fee for after hour emergencies in addition to the necessary treatment fees.

Situations of Divorce:

____ Divorced parents bringing a child to an appointment are solely responsible for all fees incurred during each visit. Parents will not be billed separately. By initialing, you agree to pay all costs of collection (if necessary) including, but not limited to, reasonable attorney's fee. As painful as divorce is for all parties involved, our office cannot become involved with parents and payment of services rendered.

I acknowledge I have read and understand all the above conditions.

Print Name:_____Date:_____

Patient/Parent Signature: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement.

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operation such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *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 healthcare operation. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

Patient Name (Print): _____

Relationship to Patient: _____

Signature: _____ Date: _____

Please list names of persons who we can release your information to:

_____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient: _____ Date of Birth: _____

Address _____

Home #_____	May we leave a message?	Yes____No_____
Work #_____	May we leave a message?	Yes____No_____
Cell #_____	May we leave a message?	Yes____No_____
Email _____	May we leave a message?	Yes____No_____

May we send an appointment reminder text message? Yes____No____
May we leave a message that you need pre-medication? Yes____No ____
May we leave a message that you need a dental appointment? Yes____No ____
I do **NOT** want a reminder left at all_____(initial)
I do **NOT** want a postcard sent_____(initial)

I understand that I <u>will</u> incur a missed appointment fee should I fail to keep my appointment (without 24hr notification). ***_____(signature)***

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the *Notice of Privacy Practices*, but was unable to do so as documented below.

Date_____ Reason_____Initials_____