ALIANA
FAMILY DENTAL

MEDICAL HISTORY

All information you supply to the office on this form and the subsequent interview with the dentist and information received from your physician or any other source will be held in the strictest confidence and will not be disclosed without your express and written permission.

PATIENT NAME: Date of birth: ___________________________

Do you now, or have you ever had, any of the following conditions?

☐ AIDS/HIV (+)	☐ EPILEPSY/SEIZURE	☐ ANXIETY/DEPRESSION	☐ ANGINA
☐ ANEMIA	☐ EXCESSIVE BLEEDING	☐ JAW JOINT PAIN	☐ COPD/EMPHYSEMA
☐ ARTHRITIS/GOUT	☐ EXCESSIVE THIRST	☐ KIDNEY PROBLEMS	☐ HISTORY OF STROKE
☐ ARTIFICIAL HEART VALVE	☐ FAINTING or DIZZINESS	☐ LIVER DISEASE	☐ OSTEOPOROSIS
☐ ARTIFICIAL JOINTS	☐ GLAUCOMA	☐ LOW BLOOD PRESSURE	☐ SINUS ISSUES
☐ ASTHMA	☐ HEART DISEASE	☐ MITRAL VALVE PROLAPSE	☐ SMOKER/TOBACCO
☐ BLOOD DISEASE	☐ HEMOPHILIA	☐ RADIATION TREATMENT	☐ STOMACH ISSUES/GERD
☐ BLOOD TRANSFUSION	☐ HEPATITIS A, B, or C	☐ RENAL DIALYSIS	☐ SWELLING OF LIMBS
☐ BREATHING PROBLEMS	☐ HERPES	☐ RHEUMATIC FEVER	☐ THYROID DISEASE
☐ BRUISE EASILY	☐ HIGH BLOOD PRESSURE	☐ RHEUMATOID ARTHRITIS	☐ TUBERCULOSIS
☐ COLD SORES	☐ HIGH CHOLESTEROL	☐ SCARLET FEVER	☐ TUMORS/GROWTHS
☐ CONGENITAL HEART ISSUE	☐ HISTORY OF CANCER	☐ SEASONAL ALLERGIES	☐ ULCERS
☐ DIABETES	☐ JAUNDICE	☐ SICKLE CELL ANEMIA	☐

☐ OTHER: ____

Are you allergic or have had any issue to any of the following?

☐ ASPIRIN	☐ LATEX allergy	☐ SULFA DRUGS	☐ OTHER_______________
☐ CODEINE	☐ DENTAL ANESTHETIC	☐ CLINDAMYCIN	☐ OTHER_______________
☐ ERYTHROMYCIN	☐ PENICILLIN	☐ AZITHROMYCIN	☐ OTHER_______________

WOMEN: ☐ Pregnant ☐ Taking birth control ☐ Nursing/Breastfeeding

Please list all medications and their dosages: ______________________________________

____

____

Are you now under the care of a physician? YES / NO If yes, for what? ______________________________________

Physician's name, address, ______________________________________

phone number: ______________________________________

Please indicate if you've had any of the following:

☐ Complications from previous dental treatment. If yes, what? ______________________________

☐ Previous hospitalizations. If so, for what/when? ______________________________

☐ An unfavorable reaction to dental anesthetics. If so, what? ______________________________

☐ Previous orthodontic treatment/braces. If so, when? ______________________________

If you could change anything about your smile, what would it be? ______________________________

I certify that I have answered all of the above to the best of my ability and I have answered truthfully.

Patient or legal guardian's signature: ______________________________ Date: ____________________

INSURANCE DISCLOSURE AND AGREEMENT

Our office strives to be up to date with most insurance companies' benefits and policies. There are hundreds of different insurance companies and different plans for individual employers. Our dentists at Aliana Family Dental are in-network with a number of insurance plans.

As a courtesy to our patients, we will call your insurance carrier and get a detailed breakdown of your benefits. We will explain these benefits to you to the best of our ability. Before any services are rendered, we will give you a treatment plan which is only an ESTIMATE of what your insurance will pay towards your treatment. Most insurance plans do not pay 100% of your cost of treatment. You are responsible for estimated co-pays at the time of service and will be responsible for any balance remaining after insurance payment regardless of reimbursement. Please know that we will do everything possible to see that you receive the full benefits from your insurance company. We are committed to helping you maximize your insurance benefits.

It takes 2-8 weeks for your insurance company to send us an explanation of benefits or an EOB. This will detail how much was actually paid on the claim.

Our relationship with you is very important to us. We do our best to give you correct information. Sometimes, though, we cannot foresee policy changes which may be put into effect by your insurance carrier. And, nor do we have control over how your insurance company will process your claim. Many variables exist from carrier to carrier (i.e. deductibles, annual maximums, allowable fee limitations, non-covered procedures, and other restrictions), therefore, we cannot guarantee any estimated charges. Because your insurance is an agreement between you and the insurance company, ultimately you are responsible for all the charges.

There are instances when your insurance company issues overpayments on claims which will leave a credit on your account to use for future treatment unless directed otherwise. In some cases, the credit may need to be returned to your insurance carrier. When requested or necessary we will issue a refund for the credit you have on your account.

I have read and understand this financial policy.

Patient/Guardian Name (please print) Patient/Guardian Signature Date

Welcome to Aliana Family Dental. We are happy to have you as our patient and look forward to offering you and your family the finest dental care available. We know that providing complete comprehensive dental services includes discussing all treatment and financial information.

Before treatment is performed, we will discuss treatment and financial options. This will allow you to fully understand your dental treatment, what to anticipate in fees and allow you time to make the necessary financial arrangements.

Payment is due at the time services are rendered. For your convenience we accept cash, checks, Visa, MasterCard, Discover, American Express, money orders or registered checks.

EMERGENCY PATIENTS:
Emergency clients, new to our practice, should expect to make a payment at the time of service. Once established as an active patient, we will be happy to discuss other payment options.

DENTAL INSURANCE:
Insurance benefits are determined by your employer, not your dentist. Your insurance policy is a contract between you and your insurance company. Your insurance coverage and benefits are your responsibility. Insurance is not a guarantee of payment; it often does not cover all the costs involved in treatment. We cannot render services on the assumption that our charges will solely be paid by an insurance company. As a courtesy, we will be happy to file your claim for you if you present your dental insurance wallet card and all required employer information. You will be expected to pay for services rendered if this office is unable to verify your insurance information before treatment.

Any deductible or estimated co-payment amount will be due at the time of treatment.

ACCOUNT BALANCES:
If payment for services already rendered has not been paid in full within 45 days, either by you or your insurance company, the remaining balance for your treatment is considered due and must be paid by you. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial agreements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of three (3) months from the date of the patient examination and may change at any time according to contracted fees with your insurance company.

APPOINTMENT CANCELLATION POLICY:
Appointments are reserved exclusively for you. As a benefit to you, our valued patient, we may offer to move your appointment to an earlier time if an opening arises. If an appointment is not cancelled at least 24 hours in advance, or if you fail to keep your appointment, you will be charged a seventy-five-dollar ($75) fee. Any missed appointment 2 hours or more in length will incur a one hundred and fifty-dollar ($150) fee. This fee will not be covered by your insurance company.

PAYMENT PLANS:
Payment plans and financial arrangements *may* be available for comprehensive dental treatment. Please speak to us to make arrangements prior to commencing treatment.

I have read and understand this financial policy.

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Patient/Guardian Name (please print) Patient/Guardian Signature Date

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ACKNOWLEDGEMENT OF RECEIPT OF *NOTICE OF PRIVACY PRACTICES*

Purpose: This form is used to obtain acknowledgement of receipt of our *Notice of Privacy Practices* or to document our good faith effort to obtain that acknowledgement. Please note that it is your right to refuse to sign this acknowledgement.

I, ______________________________________, have received a copy of this office's *Notice of Privacy Practices*.
Patient name (please print)

____
Patient signature

____
Date

OR

____
Signature of personal representative

Authority of Personal Representative to sign for patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: ____

~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.
☐ Communication barriers prohibited obtaining the acknowledgement.
☐ An emergency situation prevented us from obtaining acknowledgement.
☐ Other (please specify): ____

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FIRST NAME: ___________________________ LAST NAME: ________________________________

DATE OF BIRTH: _____________________________

ADDRESS: ____

CITY ____________________________ ZIP: __________________________ STATE: _____________

CELL#: ___________________________________ EMAIL: ____

REFFERED BY: ____ (PLEASE LIST) *

ALIANA
FAMILY DENTAL

FIRST NAME: ___________________________ LAST NAME: ________________________________

DATE OF BIRTH: ______________________________

ADDRESS: ____

CITY ____________________________ ZIP: __________________________ STATE: _____________

CELL#: ___________________________________ EMAIL: ____

REFFERED BY: ____ (PLEASE LIST) *