Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Email Address: _____ Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell) _____

Driver's License Number: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐Th

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Are You Pregnant Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Latex Allergy
- ☐ Sulfur Allergy
- ☐ Non Precious Metals
- ☐ Dental Anesthetic
  - ☐ Cholesterol
  - ☐ Thyroid Disease

Other:
☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Are you taking any medication daily? ☐ Yes ☐ No
  If yes, please list medication and dosage: _____

_____

- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail._____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Anita L Bell DDS PC

2835 Stuarts Draft Hwy
Stuarts Draft, VA 24477
540-337-1324
anitabelldds@gmail.com

Notice of Privacy Practices

By signing this form, I _____ (patient), authorize the use and disclosure of my health information as described below:

1. The purpose of this agreement is to attempt to safeguard any medical or other personal information that is provided to us. The Privacy Rule under the HIPAA requires us to maintain the privacy of medical information provided to us.

2. **What information can be disclosed?** Your name, address, phone number, any information relating to medical history, insurance information, appointments, mailings and coverage information concerning your medical and dental providers.

3. **Who can disclose this information?** Employees and staff of Anita Bell DDS PC are authorized to make use of or disclose required health information.

4. **To whom can this information be disclosed?** Organized health care entities or other medical providers in relationship to patient's health care can receive this information.
I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and send it to Anita Bell DDS PC.

I understand that it is possible that information used or disclosed with my permission may be disclosed by the recipient and no longer protected by the federal Privacy Standards.
_____ (initials of patient or guardian)

I understand that Anita Bell DDS PC may not disclose treatment on my signing this authorization and that I have a right to refuse to sign this authorization.

Patient's name _____
Guardian or patient's signature _____
Date signed _____

Anita L. Bell, DDS, PC

P.O. Box 993 Stuarts Draft, VA 24477
540-337-1324

Insurance & Financial Agreement

Thank you for choosing us to provide your dental care. This financial agreement is indicative of our respect for your right to know ahead of time our financial expectations. If you have any questions or concerns about this financial agreement do not hesitate to ask.

DENTAL INSURANCE: Your dental benefits are based upon a contract between your employer and your insurance company. If you have any questions regarding your dental benefits, please contact your human resources department or insurance company directly. We are currently a provider with Anthem, Delta Dental, Aetna, MetLife, United Concordia, Cigna, Assurant, and accept all private care insurance plans. 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 file a "pre-treatment authorization" with your insurance company prior to treatment. This is not a guarantee of coverage.

As a courtesy we will file your claims and accept assignment of dental insurance benefits provided you agree to the following: (1) you provide us with an insurance card and driver's license or other photo identification, as well as all information necessary to verify coverage and file your claim; (2) you pay your insurance does not pay within 90 days from the time a bill is submitted our office will request from you payment in full for services provided. It will then be your responsibility to collect insurance funds that are due you. Ultimately, you are responsible for all charges incurred in our office.

PAYMENT POLICY: Payment in full for your portion is required at the time of service. We accept MasterCard, Visa, American Express, Discover, cash and checks. Patients also have the option of Care Credit, which is a no to low interest credit card for which patients can apply.

RETURNED CHECK FEE: There is a returned check fee of $50.00 per check.

FINANCE CHARGES: Finance charges will be applied to all balances not paid within 30 days of the monthly billing date. A late charge of 1.5% of the balance will be assessed each month the balance is left unpaid. We understand temporary financial problems may impact timely payment of your balance. We encourage you to communicate any such problems to our office immediately so that we may assist you in the management of your account.

BROKEN OR MISSED APPOINTMENTS: Appointments not kept or changes with less than two working days notice are considered broken. Our office is only open Monday thru Thursday and, thus, only those days will be considered working days. A $65.00 per hour, with a minimum of 1 hour charge, will be applied to all broken appointments.

EMERGENCY APPOINTMENTS: In the event of an emergency appointment outside of regular business hours, a $105.00 emergency fee will be charged for established patients and $175.00 fee for new patients in addition to necessary treatment fees.

CONSENT & AUTHORIZATION: I agree to the above conditions and authorize dental treatment. I have read and understand this document in its entirety, outlining office polices and financial obligations of Anita L. Bell, DDS, PC. I agree to abide by the policies outlined herein.

Patient Signature:_____ **Date:**_____