

Broadway Dentistry

Patient, Insurance, Pharmacy, Health History, HIPAA Information & Financial Policy

Date: _____ First Name: _____ Middle Name: _____ Last Name: _____

Street: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female ☐ Unspecified SSN: _____ - _____ - _____☐ Single ☐ Married ☐ Divorced ☐ Widowed Preferred Phone #: _____ Is this a mobile number? Yes ☐ No ☐

Email: _____ Employer: _____ Title: _____

Our office utilizes an automated message system to contact our patients for upcoming appointments, reminders, and questionnaires.

Emergency Contact

Emergency Contact: _____ Emergency Phone: _____ Relationship: _____

Preferred Pharmacy

Name: _____ Phone Number: _____

Street: _____ City: _____ State: _____ Zip: _____

Responsible Party (Please fill out if other than the patient)

First Name: _____ Middle Name: _____ Last Name: _____

Street: _____ Zip: _____ City: _____ State: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female ☐ Unspecified Is This Patient a Minor? Yes ☐ No ☐ SSN: _____ - _____ - _____

Responsible Party Signature: _____ Relationship to Patient: _____

Primary Dental Insurance

Is subscriber the same as patient? ☐ Yes ☐ No First Name: _____ Last Name: _____

Date of Birth: _____ Employer Name: _____

Insurance Company: _____ Insurance Phone Number: _____

Subscriber ID/Policy Number: _____ Group Number: _____ Patient Relationship to Subscriber: ☐ Self ☐ Spouse☐ Child ☐ Disabled Dependent ☐ Other: _____

Health History

Are you under the care of a primary physician? ☐ Yes ☐ No Primary Physician's Name: _____Physician's Phone Number: _____ Date of Last Visit: _____ ☐ Greater than 4 years ☐ I do not knowAre you taking or have you taken any steroid/cortisone therapy in the last 2 years? ☐ Yes ☐ No If Yes, Explain: _____

Are you taking, or have you taken Oral Bisphosphonates (e.g., FOSAMAX, BONIVA) or IV Bisphosphonates, (e.g.,

ZOMETA, AREDIA)? ☐ Yes ☐ No How Long? _____ Have you ever been hospitalized? ☐ Yes ☐ No Please List

Specifics: _____

Do you require antibiotics prior to dental procedures? ☐ Yes ☐ No

Please List Prescribing Physician: _____ List Reason for Pre-Med Antibiotics: _____

Prescription Prescribed: _____ Last Date Prescription Filled: _____

Health History ContinuedAre you allergic or have had an adverse reaction to any of the following? ☐ None ☐ Amoxicillin ☐ Aspirin ☐ Codeine ☐ Epinephrine☐ Latex ☐ Metals ☐ Novocain ☐ Penicillin ☐ Sulfa ☐ Tetracycline ☐ Other: _____Please list any medications you are taking including non-prescription drugs and herbals/vitamins: ☐ None ☐ Yes

Circle any conditions that apply to you:

- | | | |
|---------------------------------|---------------------------|---------------------------------|
| • Alcoholism/Drug Use/Addiction | • Heart Murmur | • Date: _____ |
| • Allergies or Hives | • Heart Surgery | • Rheumatic Fever |
| • Artificial Heart Valve | Date: _____ | • Seizures |
| • Anemia | • Heart Attack/CHF/Issues | • Sexually Transmitted Diseases |
| • Arthritis | • Type: _____ | • Sinus Issues/Problem |
| • Artificial Joint/Pins | • Hepatitis | • Smoke/Tobacco/Chew/Vape |
| • Type: _____ | Type: _____ | • Stroke |
| Date: _____ | • High Blood Pressure | • Thyroid |
| • Asthma | • HIV/AIDS | • Tuberculosis (TB) |
| • Blood Thinners | • Kidney Disease/Dialysis | • Ulcers |
| • Blood Transfusion | • Liver Disease | • Visual Impairments |
| • Breathing Problems | • Low Blood Pressure | • Other Diseases/Illness |
| • Cancer | • Lung Disease/COPD | • Type: _____ |
| • Type: _____ | • Lupus | _____ |
| • Chemotherapy | • Mobility Impairment | _____ |
| • Coumadin Therapy | • NON-DENTAL Implants | _____ |
| • Dementia | • Type: _____ | _____ |
| • Diabetes | • Organ Transplants | _____ |
| Type: _____ | • Type: _____ | _____ |
| • Dialysis | • Pacemaker | _____ |
| • Excessive Bleeding | • Psychiatric Care | |
| • Fainting/Dizziness | • Radiation Therapy | |

Female Patients:Are you currently pregnant? ☐ Yes ☐ No Could You Be Pregnant ☐ Yes ☐ No If Yes, Estimated Delivery Date: _____Are you currently nursing? ☐ Yes ☐ No Are you currently using contraceptives? ☐ Yes ☐ No If yes, List: _____****NOTE:** Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Please consult your physician/gynecologist for assistance regarding additional information. ****Oral/Dental Health History**Reason for Visit: ☐ Check-up ☐ X-Rays ☐ Tooth Pain ☐ Broken Tooth: Date of Last Dental Visit: ____/____/____☐ I do not know exact date ☐ Last 6 months ☐ 6 months- 1 years ☐ 1-3 years ☐ Greater than 4 years ☐ Never ☐ Other: _____

Previous Dentist: _____ Referred By: _____

Oral/Dental Health History ContinuedHave you ever been treated for periodontal disease: ☐ Yes ☐ No Have you ever had Novocain/other local anesthetics: ☐ Yes ☐ NoHow happy are you with your smile (1-10)? _____ Are you currently wearing any type of denture/partial: ☐ Yes ☐ NoAge of dentures/partials: ☐ Less than 6 months ☐ 6 months – 3 years ☐ Greater than 4 years**Please check any conditions that apply to you below:**☐ Pain in Jaw (TMJ) ☐ Teeth Grinding/Clenching ☐ Use of Tobacco Chewing Products ☐ Mouth Sores ☐ Sensitive Teeth ☐Swollen Gums ☐ Bleeding Gums ☐ Broken/Loose Teeth ☐ Difficulty Chewing/Swallowing ☐ Salivary/Lymph Gland Concerns

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to perform an examination and diagnose my condition. I also give my consent for any preventive or basic restorative procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Patient/Guardian's Signature: _____ **Date:** _____

**I hereby authorize that the office of Broadway Dentistry to leave messages
on my voicemail/texts to inform myself of appointments and/or treatment ☐ Yes ☐ No**

HIPAA Authorization for Release of Health Records to External Parties☐ I do **NOT** authorize the disclosure of any information from my treatment records☐ I authorize the disclosure of information from my treatment records to **(Optional)**:Name of 1st Recipient: _____ Relationship to the Patient: _____Name of 2nd Recipient: _____ Relationship to the Patient: _____

I give authorization to disclose the following information

☐ **ALL** treatment information☐ Information related to these treatment dates

Starting Date: _____ End Date: _____

Financial Policies

Since you are a valued patient and person in our dental practice, we wanted to have a sincere and honest explanation for our financial and insurance policies. We believe in order to give the best possible care to our patients we need to inform you of the following information. We ask that you read and fully understand the information below. We encourage you to discuss any question you may have. These policies are effective immediately.

Thank you for your trust in us. **Please Initial:** _____**Payment Policy**

Payment in full is required at the time each service is completed. We accept cash, checks, money orders, Visa, MasterCard, American Express and Discover. If necessary, we can help you arrange for financing through CareCredit. There will be a \$25.00 charge for returned checks.

INSURANCE/ THIRD PARTY CARRIERS

Insurance companies offer a variety of policies, difference coverages, deductibles, limitations, and clauses depending on your specific contract. It is your responsibility to check and update this information with our office.

We will submit your claim on your behalf for any PPO plan, providing you give us all the information we need. Your insurance company will reimburse you/us directly based on your network benefits. **Please Initial:** _____

Financial Policies Continued

Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of claims. Reduction or rejection of your claim by your insurance does not relieve you of the financial obligation you have to us. The patient is responsible for payment (in full) of their dental care within 60 days of treatment—regardless of the status of the claim. Your insurance questions should be directed to the telephone number provided to you by your insurance company. Please Initial: _____

Attention Delta Dental Patients: Delta will be paying the portion covered by your individual policy to **YOU** directly. This will require us to collect the fee in full at the time of service. If your insurance needs additional information, it is your responsibility to provide us with the Explanation of Benefits (EOB) provided to you in 14 days after receiving it. Please Initial: _____

How do you plan to pay for today's services? ☐ Cash ☐ Check ☐ Debit/Credit ☐ CareCredit Payment Plan

Please Initial: _____

The point of service collection terms require a secure valid card be on hold for all patients. This card will only be charged in accordance with the terms listed below. Please Initial: _____

- 1) We request the right to charge a missed appointment fee of 1/3 of your larger treatment appointment total or \$50 per hour for hygiene appointments.
- 2) Your insurance company requires benefits be paid to the member opposed to the provider. Once services are preformed payment from patient is required in full, unless other payment arrangements have been made prior.

We Accept



Card Holder's Name: _____

Credit Card Number: _____

Expiration Date: _____ CV2 Code: _____ Billing Zip Code: _____

Driver's License State: _____ Driver's License Expiration Date: _____

Appointment Scheduling Policy

A scheduled appointment is a commitment of time between the Doctor and the patient. We have reserved that time JUST FOR YOU. When appointments are missed or canceled, the time is lost.

We ask that when you schedule your treatment, you make every effort to keep that commitment. We understand that personal emergencies do arise, and we always take that into consideration.

If you cannot keep your scheduled appointment, a 48-hour working day notice will allow us to schedule another patient in need of treatment.

I understand that a missed appointment fee of \$50 per hour will be charged if a 48-hour working day notice is not given
_____ initial. We are not here currently on Friday's or weekends.

Dental Insurance

Out of courtesy and convenience for our patients we offer to file your insurance on your behalf. If you have dental insurance, it is the patient's responsibility to update their status information with our office. It is the patient's responsibility to stay abreast and informed of all insurance changes their policy invokes.

Financial Policies Continued

Broadway Dentistry accepts payment from non-affiliated, third-party finance companies. Credit decisions are the responsibility of these third-party finance companies and of the patient.

I, undersigned, accept full financial responsibility for the treatment performed by this office, insurance forms will be completed as a convenience to the patients. Should the services of an attorney be required for collection of this account, I agree to pay reasonable attorney's fees, court costs, and other costs of collection.

Printed Full Name of Responsible Party: _____

Signature of Responsible Party: _____

Date: _____

Patient Signatures**Patient, Insurance, Pharmacy, Health History, HIPAA Information & Financial Policy**

By signing below, I (**patient/guardian name**) _____ acknowledge that I received the Payment, Insurance, and Financial Policies forms and agree to abide by such policies. I acknowledge that I have read the Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Release of Information to Insurers and Assignment of Benefits (must be signed by all patients with insurance and those who expect to obtain insurance). To the extent permitted by law, I consent to my practice (or their designees) use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claims. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize my direct payments of benefit to be authorized and payable to this dental office.

Printed Full Name of Patient: _____

Patient Date of Birth: _____

Signature of Patient: _____

Date: _____

-OR-

Printed Full Name of Responsible Party: _____

Responsible Party Date of Birth: _____

Signature of Responsible Party: _____

Date: _____

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section)

Broadway Dentistry
Denise C. Acosta D.M.D.

3611 Broadway
Fort Wayne, Indiana 46807

Phone: 260-456-3406 Fax: 260-456-3055
Email: jenna@broadwayllc.com

*Thank
You!*