Loftin
Dental Center

New Patient Information 2024

Welcome to our office!

PERSONAL INFORMATION

Name: _____ Birthday: _____/_____/_____ Sex: _____M _____F

Address: _____ Driver's License /ID #: _____ State: _____

City/State: _____ Zip: _____ Social Security #: _____

Phone: _____ Work: _____ Employer: _____

Marital Status: Single/ Married/ Divorced/ Widowed/ Separated Address: _____

Email: _____ Employer Phone: _____

Emergency Contact Name: _____ Reason for Today's Visit: _____

Phone: _____ Relation: _____ Is this accident related? □ Yes □ No

PARENT/GUARDIAN INFORMATION *(must complete if under the age of 18)*

Name: _____ *Birthday:* _____/_____/_____ *Sex:* _____M _____F

Address: _____ *Driver's License /ID #:* _____ *State:* _____

City/State: _____ *Zip:* _____ *Social Security #:* _____

Relationship: Mother/Father/Grandparent/Other: _____ *Phone Number:* _____

Emergency Contact: _____

Relationship: Mother/Father/Grandparent/Other: _____ *Phone Number:* _____

PRIMARY DENTAL INSURANCE INFORMATION

Policy Holder: _____ Policy Holder SSN #: _____

Group/Company Name: _____ Policy Holder Date of Birth: _____

Insurance Member ID #: _____ Address (if Different): _____

PRIMARY PHYSICIAN/ SPECIALIST

Physician Name: _____ Specialist: _____

Phone: _____ Phone: _____

Pharmacy: _____

All medical history must be listed here to accommodate your visit correctly.

MEDICAL HISTORY

Have you been tested for sleep apnea? □ Yes □ No

Have you been diagnosed /treated for TMJ or TMJD? □ Yes □ No

Do you require a premedication prior to treatment? □ Yes □ No **(PREMED)**

Are you allergic to Penicillin, Aspirin, or any other drug? □ Yes □ No Other: _____

Have you ever had a reaction to Novocain or Anesthesia? □ Yes □ No Date: _____

HAVE YOU EXPEREINCED ANY OF THESE CONDITIONS IN THE LAST 4-6 WEEKS?

Active pink eye? □ Yes □ No

History of Head Lice? □ Yes □ No Currently have Head Lice? □ Yes □ No Last Date of Treatment: _____

Are vaccinations up to date? □ Yes □ No

For women only: Are you pregnant? □ Yes □ No Nursing? □ Yes □ No Had exposure to HPV? □ Yes □ No

HAVE YOU EVER USED A BISPHOSPHONATE MEDICATION? FOSAMAX, ACTONEL, ATELVIA, DIDRONEL, BONIVA. **□ YES □ NO**

*****Please continue on the backside of this sheet*****

Past or Present History of (Circle all that apply): □ **None Apply**

Accidental Injury to teeth/mouth
Blisters on Lips, Tongue, Mouth, Cold Sores
Burning of Tongue
Chew on One Side of Mouth
Clench/Grind Teeth
Dental Fractures
Dry Mouth
Growths or Lesions in Mouth
Gums Swollen, Tender, Bleeding
Head, Neck, Jaw Pain
Lip or Cheek Biting
Loose Teeth or Broken Fillings
Mouth Breathing
Orthodontic Treatment
Sensitivity to Hot/Cold
Periodontal Treatment
When was your last dental visit? _____
How often do you floss? _____
How often do you brush your teeth? _____
Are you in pain? _____
Is the damaged tooth a capped or previously restored tooth? _____

Have you had any of the following? (Circle all that Apply) or Check □ **None Apply**

AIDS/HIV
Anaphylaxis
ADD, ADHD
Autism
Anemia
Diabetes, Swelling of Feet/Ankles
Arthritis, Rheumatism, Cortisone Treatments
Artificial Heart Valves/Joints/ Mitral Valve Prolapse
Asthma, Shortness of Breath, Respiratory Disease
Atopic (Allergy Prone)
Anxiety, Depression
Heart Surgery, Pacemaker
Artificial Joints, Surgical Implant
Heart Attack/Stroke
Back Problems, Spine Bifida
Blood Disease
Cancer/ Chemotherapy/ Radiation Treatment
Chemical Dependency, Tobacco Habit
Circulatory Problems, Blood Transfusion
Cortisone Treatments
Cholesterol □ High □ Low
Epilepsy/Seizures
Cough, Coughing Blood
Food Allergies
Fainting
Headaches/Migraines
Glaucoma/Cataracts
Heart Murmur/Problems
Hemophilia/ Abnormal Bleeding
Herpes
Psychiatric Care/Bipolar
High Blood Pressure
Shingles, Skin Rash, Scarlet Fever
Muscular Disease: _____
Hepatitis (A B C)
Liver Disease/ Cirrhosis
Kidney Disease. Malfunction
Thyroid Disease, Malfunction, Tonsillitis
Material Allergies: Latex, Wool, Metal, Chemicals
Tuberculosis
Ulcer/Colitis
Venereal Disease

Are there any other health conditions you may have that are not listed? _____

MEDICATIONS

Does the patient have any drug allergies? If Yes, list all. □ **No Know Allergies**

_____
_____
_____

Please list **ALL** medications you are currently taking: □ **None at this time**

_____
_____

*****Please continue on next page****

HIPPA Privacy Policy

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected heath information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (i.e., my insurance company)
- The day-to-day healthcare operation of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to theses requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: _____ Relation to Patient: _____

Signature: _____ Date: _____

Staff Member: _____

HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

***** We Will Not Disclose Any Information to Anyone Unless Listed on This Form*****

Name: _____ Relationship: _____

Address: _____ Phone #: _____

Name: _____ Relationship: _____

Address: _____ Phone #: _____

Health information to be disclosed upon the request of the person name above. (**Check either A or B**):

☐ A. Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions)

☐ B. Disclose my health record, as above, **BUT DO NOT** disclose the following (check as appropriate):

- ☐ Mental Health Records
- ☐ Communicable Diseases (including HIV & AIDS)
- ☐ Alcohol/ Drug Abuse Treatment
- ☐ Other: _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

☐ An electronic record or access through an online portal

☐ Hard copy

☐ All past, present, and future periods

Date or event: _____unless I revoke it. (Note: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

Printed Patient Name: _____ Date: _____

Patient Signature: _____

Staff Member: _____

*****Please continue on the backside of this sheet*****

Office Policies

Loftin
Dental Center

We, the staff of Loftin Dental Center, thank you for choosing us as your dental/health provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is not only to inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time, you have any questions or concerns regarding our fees, policies, or responsibilities please feel free to contact **Tiffany** at **361-664-8352**.

We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients. Please understand that payment for services is an important part of the provider-patient relationship. In order to keep our costs reasonable, we require payment at the time of service unless our staff has approved payment arrangements in advance. We make payment as convenient as possible by accepting (Cash, Money Order, MasterCard, Visa, Care Credit and in-state checks). A $35.00 service fee will be charged for all returned checks. You may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. We have found that insurance companies may try to limit or dictate the services, or level of service a provider can offer to their patients. This leaves the provider of service and the patient with a direct relationship and the opportunity to make the final decision as to which treatments are most beneficial for the patient. We have found that insurance carriers will request needless and redundant information from a provider of service much more frequently than a patient will. If you have insurance, we will bill your carrier and provide you with a copy of your claim for billing purposes. Any requests for additional forms from your insurance company will gladly be accommodated. This includes records, reports, tests, etc. We will provide you with the additional information to submit to your insurance company so there can be no doubt in your mind that we are complying with their request. Please retain the original copy for your files. If we are not contracted with your carrier, we will not negotiate reduced fees with your carrier.

Missed Appointments

We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. Repeated missed appointments (3) without notification may cause you to be set on a "walk-in only" our practice so that we can provide care to other patients.

Medical Records

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines, and exceptions to ensure compliance to patient rights. We require a prior signed authorization of medical release by the patient. Please indict all authorized person(s) you are authorizing. Authorized person(s) must present valid identification upon request.

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

I have read and understand the above financial policy. I agree to assign insurance benefits to whenever applicable. I also agree, in addition to the amount owed, I will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

_____ _____

Patient/Guardian Signature Date

Insurance Policy

***Pease read in full prior to signing as it pertains to your insurance claims*

Loftin Dental Center processes your claims as a courtesy. We will only process primary in network claims at this time. Assignment of benefits is selected to sure proper payment is made to our facility. If your plan does not allow the assignment of benefits option, you are solely responsible for any payments issued to you by your insurance provider for services rendered at our practice. Loftin Dental Center will allow 30 days from your check clearance date to submit payment to us. If no payment is made, you will be charged private pay fees. If your insurance company pays directly to the member, Loftin Dental Center will ask for full payment at time of treatment. As of 2023, we will longer bill secondary insurances. Please ask for a detailed statement after your visit for self-submission to your secondary insurance. If there is an error with your insurance or it is not presented 48 hours prior to your visit, you are solely responsible for all private pay fees. Patient may seek reimbursement once paid EOB is presented.

There is no guarantee of payment until your claim is reviewed by the insurance claims department. Loftin Dental Center will appeal denials at no charge once. If an approval cannot be obtained, you will be solely responsible for any remaining balance for all services rendered.

This policy also extends to inactive insurance status at time of treatment. If you are due to terminate of your policy or employment, your insurance company may retro date all services at any time to reflect your termination date. This balance will be solely your responsibility.

Signing below states that you understand this policy and take full responsibility for finances.

_____ _____

Patient/Guardian Signature Date