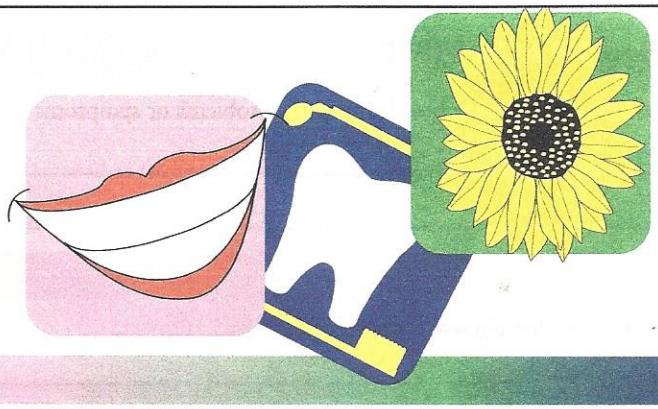
WELCOME
to our practice!

Please take a few minutes to answer the following questions so we can better assist you with your health care needs.



PATIENT INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____
Last Name First Name Initial

Address _____ Home Phone _____

City _____ State _____ Zip _____

Sex: ❑ M ❑ F ❑ Minor ❑ Single ❑ Married ❑ Long Term Partner ❑ Divorced ❑ Widowed ❑ Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Address _____

Subscriber I.D. # _____ Group # _____

ADDITIONAL INSURANCE

Insured Name _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Address _____

Subscriber I.D. # _____ Group # _____

PLEASE COMPLETE REVERSE SIDE

REASON FOR VISIT

Please list your present health concerns, problems or symptoms _____

_____

_____

When was your last physical exam? _____

Physician's Name _____ Phone _____

	Yes	No
1. Are you currently under medical treatment?	❑	❑
Please describe: _____		
2. Have you ever had any serious illnesses or operations?	❑	❑
Please describe: _____		
3. Are you currently taking any medication?	❑	❑
Please describe: _____		
4. Do you smoke?	❑	❑
5. Do you use alcohol?	❑	❑
6. Do you use cocaine or other drugs?	❑	❑

7. Have you had any allergic reactions to the following:	Yes	No
Local Anesthetics (eg. novocaine)	❑	❑
Penicillin or other Antibiotics	❑	❑
Sulfa Drugs	❑	❑
Barbiturates (sleeping pills)	❑	❑
Sedatives	❑	❑
Iodine	❑	❑
Aspirin	❑	❑
Other	❑	❑
Please describe: _____		

8. Women Only:	Yes	No
Do you have regular periods	❑	❑
Are you taking birth control pills	❑	❑
Have you ever been pregnant	❑	❑
Number _____		

Have you ever had the following:	Yes	No
Anemia (low blood count)	❑	❑
Anorexia (no appetite)	❑	❑
Arthritis	❑	❑
Asthma	❑	❑
Back Problems	❑	❑
Bleeding Tendency	❑	❑
Blood Disease	❑	❑
Cancer	❑	❑
Chemical Dependency (Addiction to drugs)	❑	❑
Chemotherapy	❑	❑
Chicken Pox	❑	❑
Chronic Fatigue Syndrome	❑	❑
Circulatory Problems	❑	❑
Congenital Heart Lesions	❑	❑
Cough - persistent or bloody	❑	❑
Diabetes	❑	❑
Emphysema	❑	❑
Epilepsy	❑	❑
Glaucoma	❑	❑

	Yes	No
Heart Murmur	❑	❑
Heart Disease	❑	❑
Hepatitis-Type ____	❑	❑
Hernia	❑	❑
Herpes	❑	❑
High Blood Pressure	❑	❑
HIV/AIDS	❑	❑
Jaundice	❑	❑
Kidney Disease	❑	❑
Latex Sensitivity	❑	❑
Liver Disease	❑	❑
Low Blood Pressure	❑	❑
Measles	❑	❑
Migraine Headaches	❑	❑
Mitral Valve Prolapse	❑	❑
Mumps	❑	❑
Multiple Sclerosis	❑	❑
Pacemaker	❑	❑
Pneumonia	❑	❑

	Yes	No
Polio	❑	❑
Prostate Problem	❑	❑
Psychiatric Care	❑	❑
Respiratory Disease	❑	❑
Rheumatic Fever	❑	❑
Scarlet Fever	❑	❑
Shortness of Breath	❑	❑
Sinus Trouble	❑	❑
Skin Rash	❑	❑
Stroke	❑	❑
Thyroid Problems	❑	❑
Tonsillitis	❑	❑
Tuberculosis	❑	❑
Ulcer	❑	❑
Venereal Disease	❑	❑
Any Other Condition	❑	❑
Please describe: _____		

MEDICAL HISTORY

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

DAVID C. ZIEG D.D.S.

Office Financial Policy and Agreement

Payment is due at the time of service rendered.

For your convenience, we accept cash, check, Visa, MasterCard and Discover. For those who qualify, we also accept Care Credit for patients who would prefer to make monthly payments, spreading the cost of their treatment over time. If you are interested in making arrangements with Care Credit please ask our team for more information.

Payment plans and financial arrangements must be made ***prior to*** comprehensive treatment.

Dental Insurance

As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

- Insurance benefits are determined by your employer and insurance company, not by your dentist.
- Not all the services we provide are covered benefits. Benefits differ from one company to another.
- It is the patients' responsibility to understand that terms and conditions of their individual insurance contract.
- Insurance is not a guarantee of payment. If we are unable to file your insurance, the balance due is the patients' responsibility.
- Any balance on account after 45 days is the patients responsibility. A service charge will be assessed monthly on all accounts over 60 days.
- Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely the patients' responsibility. Receiving our services indicates your acceptance of responsibility of payment.

If you fail to bring the required insurance information to your appointment we will ask that you pay the bill in full and be reimbursed from your insurance company with paperwork provided by our office.

Non-insured Patients

We provide written estimate of fees, and payment is expected at each visit for services rendered.

We understand that temporary financial problems may affect timely payment of your balance. In those situations, we encourage you to communicate any such problems *immediately* so we may assist you in the management of your account.

Overdue Balance

An account with an unpaid balance past 90 days will be sent to the collection agency. At that time, you will be responsible for any and all cost incurred on your account.

We reserve the right to charge and collect fees for broken appointments. **Appointments that are cancelled or broken without 24 hour notice may be charged a $40 fee**. *Appointments are reserved exclusively for you and therefore we stress you understand the importance of keeping said appointment, or informing us for the need to reschedule.*

Returned check fee of 35.00 will be added to your account balance and is collectable by our office.

Consent and Authorization

I hereby do authorize dental treatment and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understand this document in its entirety, outlining office policies and financial policies of David C. Zieg D.D.S., P.C. I agree to abide by the policies outlined herein.

Printed name_____Date_____

Signature_____Date_____

In Case of Child:

Relationship to child_____Date_____
Are you the person legally responsible for this child? Yes_____No_____

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: ____/____/____

Witness:_____ Date: ____/____/____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

This practice is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Treatment
We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment or health care operations. (example)

"*On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with this practice."*

"It is our policy to provide a substitute health care provider, authorized by this practice, to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, illness, or other emergency situation."

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to this practice for health care series rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes with describe the health care services received."

Workers' Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medication, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons
We may disclose your health information to coroners or medical examiners.

Organ Donation
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Appointments

We may contact you for appointment purposes as described below:

"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

Change of Ownership

In the event that this practice is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that this practice is not required to agree to the restriction that you requested.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have the right to inspect and copy your health information.

You have a right to request that this practice amend your protected health information. Please be advised, however, that this practice is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protected health information made by this practice.

You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

This practice reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, this practice is required by law to comply with this notice.

This practice is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about your privacy rights, please contact our office.

This notice is effective as of _____/_____/_____

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____

Patients Name (print)

_____ _____

Patients Signature Date

_____ _____

Authorized Facility Signature Date