Dental Care Associates
Howard M. Spector, DDS
6649 N. High St. - Suite 201
Worthington, Ohio 43085
Phone: (614) 436-8336
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Welcome To Our Practice

We provide care for most insurance companies. We are aware of rising health care costs and are striving to enable our patients to complete all the dental treatment they require. We can provide this care through efficiency of office management.

Missed appointment time jeopardizes our ability to continue to participate as a network provider in your dental insurance plan. Therefore, a $15.00 fee per 30 minutes of appointed time will be assessed for appointments broken without 24 hours notice to change or cancel. This ensures all our patients can be seen and cared for as needed.

Thank you for reading and understanding this policy.

_____

Signature Date
Patient, Parent or Guardian

NEW PATIENT INFORMATION FORM

LAST NAME: _____ FIRST NAME: _____

MIDDLE NAME: _____ NICK NAME: _____

HOME ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____ SS#: _____

DOB: ____/____/____ MARITAL STATUS: _____ SEX: _____

SPOUSE/ GUARDIAN'S NAME:_____

WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

PRIMARY INSURANCE COVERAGE

SUBSCRIBER NAME AND ADDRESS: _____

RELATION TO PATIENT: _____SS#: ____-____-____ DOB: ____/____/____

EMPLOYER NAME AND ADDRESS: _____

INSURANCE COMPANY NAME AND ADDRESS: _____

GROUP/ ID #: _____

SECONDARY INSURANCE COVERAGE

SUBSCRIBER NAME AND ADDRESS: _____

RELATION TO PATIENT: _____ SS#: ____-____-____ DOB: ____/____/____

EMPLOYER NAME AND ADDRESS: _____

INSURANCE COMPANY NAME AND ADDRESS: _____

GROUP/ ID #: _____

EMERGENCY CONTACT:

NAME & ADDRESS: _____

PHONE #:_____

Signature: _____

Patient's Name: _____

DENTAL HISTORY

Last Dental Visit:_____ Purpose: _____ Last Complete Exam:_____
Name of previous dentist: _____
Have you been having any specific problems: _____
How would you rate your present dental health : Good Fair Poor
Do you think you have active dental disease? Decay Gum Disease No
Do your gums ever bleed? No Yes
Has a fear of discomfort kept you from regular visits? No Yes
Are you troubled with bad breath? Sometimes No Yes
Any unusual effects from a previous dental experience? No Yes
Do you play sports? No Yes
Do you wear a mouth guard? No Yes
Anything you would like to change about your smile? _____

MEDICAL HISTORY

Physician's Name:_____Last Visit: _____
Have you been a patient in a hospital during the past 2 years? No Yes
Are you now under the care of a physician? No Yes
Have you taken any kind of medicine or drugs in the last 6 months? No Yes
If yes, please list _____
Are you allergic to any drugs or medication? (penicillin, codeine, etc.) No Yes
If yes, please list _____
Have you had any excessive bleeding requiring special treatment? No Yes
(WOMEN) Are you pregnant now? No Yes

Please check(✔) all that apply:

___Organ Transplant	___Blood Transfusion	___Heart Attack
___Joint Replacement Surgery	___Heart Trouble (Stent or Shunt)	___High Blood Pressure
___Cancer Therapy	___Sjogren's Syndrome	___Autoimmune Disease
___Persistent Cough	___Hepatitis	___Epilepsy
___Tuberculosis	___Stroke	___Diabetes
___Arthritis	___Test HIV Positive	___Asthma
___Rheumatic Fever	___Psychiatric Treatment	___Allergy to Latex

Do you have any other medical conditions that we should know about?
Please describe:_____

The above information is accurate and complete to the best of my knowledge.
Date: _____ Patient/Guardian Signature: _____

Date: _____ Staff Signature: _____

HIPAA Consent Form

Patient Name :_____

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HIPAA Notice of Privacy Practice

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy practice is to explain how Dental Care Associates may use or disclose your health care information. The Notice also explains the rights that you guaranteed under HIPAA regulations.

Though Dental Care Associates has always taken great care to protect the integrity and confidentiality of your health care information, we are now required by the HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgment that you have received the Notice.

Signing below indicates that you have received the Notice of Privacy Practice. If you have any questions, please contact our office at (614) 436-8336.

I hereby acknowledge that I have received a copy of Dental Care Associates Notice of Privacy Practices.

_____
Initials of Patient/Guardian

Permission to Share Medical Information

My medical information my be obtained and exchanged verbally to:

_____ _____
Name/Relationship Initials of Patient/Guardian

Permission to Bill Your Insurance

All professional services rendered are charged to the patient. Necessary forms will be completed by the office of Dental Care Associates to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage.

I understand my signature authorizes releasing of the information to the insurer or agency given to Dental Care Associates for participating health insurance plans.

_____ _____
Signature of Patient/Guardian Date

DENTAL CARE ASSOCIATES AND YOUR INSURANCE PLAN – HOW THEY WORK TOGETHER

Our staff is pleased that you have insurance benefits to help with the cost of your dental care. We would like to help you obtain the maximum use of these benefits. With this in mind, please read the information on our insurance claims process so that we can work together to ensure this benefit.

DO YOU ACCEPT MY INSURANCE? HOW MUCH WILL THEY PAY?

We currently accept a wide variety of dental insurance plans. This means that we work with literally thousands of companies, Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but this is ONLY AN ESTIMATE. If you would like to know your exact insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. This does delay treatment but will give you the exact out of pocket figures you may require.

I THOUGHT I PAID MY PORTION BUT I GOT A BILL, WHY?

We base the patient portion of you bill on our most current data but there are many factors that can affect this estimate. There may be a deductible (individual or family) or you may have received treatment in another office prior to joining our practice, which is not calculated into our database. Sometimes you may need to see a specialist for care, which also uses your annual benefit. Insurance companies do not (and cannot in most cases) notify us of changes to your benefits, they only notify you. If these situations apply to you, please let us know when we estimate your treatment plan so we may adjust accordingly.

INSURANCE DIDN'T PAY, NOW WHAT?

We bill your insurance as a courtesy. If insurance does not pay within 90 days, Dental Care Associates reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. A 1.5% interest charge is added to all outstanding balances due over 30 days. This is rare, but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

FINANCIAL OPTIONS

Dental Care Associates does request payment in full for your portion at the time of service. We accept MasterCard and Visa. If you are in need of an extended finance option, we also work with Care Credit financing, who offers a six month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs. Just ask on of our office staff for an application.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at Dental Care Associates.

_____ _____

Signature Date