Patient Information

Welcome to our office!

Patient Name: _____ Preferred Name: _____
Last First MI

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

Social Security #: _____ Birth Date: _____

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

•Best time to reach you? ☐Morning ☐Afternoon ☐Evening •At what number? ☐Home ☐Work ☐Cell

Home Address: _____

City: _____ State: _____ Zip/Postal Code: _____

Employer Name: _____

E-mail Address: _____ Do you check your e-mail regularly? ☐Yes ☐No

Are there any members of your immediate family who are patients in our office? ☐Yes ☐No
If yes, please list: _____

~~If Patient is a child, Parent/Guardian information:~~

Name: _____
Last First MI

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

•Best time to reach you? ☐Morning ☐Afternoon ☐Evening •At what number? ☐Home ☐Work ☐Cell

Home Address (If different from above): _____

How did you hear about us?

Who can we thank for referring you, a patient of ours? or other? _____

Or, was it one of the following: ☐ Our website, www.odental.com ☐ Other _____
☐ Our sign ☐Yellow pages
☐ Newspaper

Financial Policy

As a condition of treatment by this office, I have read the included *Financial Policy* and I agree to the terms stated therein. I also grant my permission to telephone me at home or at my work to discuss matters related to this form.

_____ **Date:** _____ **Relationship to patient:** _____

_____
Signature of patient, parent or guardian

Loughlin Dental

Preferred Name: _____

Medical Information

check any of the following that apply:

□ High Blood Pressure
□ Heart Attack If so, when: _____
□ Artificial Joint If so, what: _____
□ Heart Murmur
□ Radiation Tx, If so, when:_____
□ Diabetes
□ Penicillin Allergy
□ Latex Allergy
□ Codeine Allergy
□ Tuberculosis
□ Pacemaker
□ Cancer

Other Allergies:
_____
□ Hepatitis
□ Abnormal/Excess Bleeding
□ AIDS/HIV
□ **None of the above**

● Have you ever been pre-medicated before a dental appointment due to medical reasons? ☐Yes ☐No
● Name of primary physician: _____ Are you currently being treated for anything speci
☐Yes ☐No If yes, please explain: _____
● Medications you are taking (including herbal supplements): _____
_____

For Women . . . ● Are you pregnant? ☐Yes ☐No ● Are you nursing? ☐Yes ☐No
● Are you taking contraceptives or other hormones? ☐Yes ☐No

☐No If yes, please explain: _____

● Date of last dental exam: _____ ● Date of last dental cleaning: _____
● Have you ever had any complications or allergic reactions following dental treatment? ☐Yes ☐No If yes, please

Dental Information

explain: _____
● Do you ever awaken with head or jaw pain of unknown origin? ☐Yes ☐No
● Are you interested in whitening your teeth? ☐Yes ☐No
● Have you thought or are you interested in straightening your teeth? ☐Yes ☐No
● Are you happy with the appearance of your teeth? ☐Yes ☐No
● If you could, what would you change about your teeth or smile? _____
● Is there anything we can do to make your visits more comfortable? _____

● How would you rate your fear/anxiety about coming to the dentist, on a scale from 1 to 10:
. ('1' = No fear," I love coming to the dentist and '10' = great fear, "I'd rather be doing anything else!") *… Please circle one:*

1 → 2 → 3 → 4 → 5 → 6 → 7 → 8 → 9 → 10

● ***To make your visit here as pleasant as possible, the following are available upon request:***

Television, Sunglasses, Blanket, Neck Pillow, Nitrous oxide (also known as *laughing gas*), Noise canceling headphones

To the best of my knowledge, all of the preceding answers and information provided are true and correct.

_____ Date: _____ Relationship to patient: _____

Signature of patient, parent or guardian

Signature of patient, parent or guardian

O'Loughlin Dental, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, , have received a copy of this office's Notice of Privacy Practices.

{Please Print Name}

{Signature}

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

O'Loughlin Dental, LLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (11/24/03), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: *You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice*

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Tina

*Telephone: (660) 263-2002 *Fax: (660) 263-2029 *Address: 1710 Gratz Brown, Moberly, MO 65270

Financial Policy for our Patients

Our office wants all our patients to be able to comfortably afford the dental care that is needed. We are proud to offer the following payment options in order to make your dental experience more convenient.

If you have dental insurance… Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of the cost of treatment. Because of this, you will be asked to pay your deductible and portion of the charges on the day the services are rendered. For your convenience, we will estimate as closely as possible your coverage, but we can make no guarantee of any estimated coverage.

Because the insurance policy is an agreement between you and your insurance company, the ultimate responsibility for all charges lies with you. If after 60 days the insurance company has not paid on the claim, you will be responsible for the balance of the claim.

Payment Options:

- Patients with no insurance that pay **in full** for their treatment will receive a 5% discount. (**excludes** payment by CareCredit)
- *Credit Card:* We accept Visa, MasterCard, American Express and Discover.
- *Make Payments with one of the following options:*
  CareCredit: Upon approval, patients can make payments on their treatment through an outside finance company with no interest charges in most cases (We pay your interest!)
  Automatic Credit Card Payment: For any treatment over $1,000 we will charge your credit card in up to six equal payments spread over a maximum of six months. The first auto payment being taken out on the first day of service.
- *Senior Citizen Discount:* As a courtesy to anyone 65 years and older, we will gladly discount your fee by 10% if services are paid in full at the time of treatment.

Bad Checks: A service charge of $25 will be assessed for any bad check.

Finance Charge: A finance charge of 1.5% each month will be added to accounts over 60 days.

Outstanding Balances: As a small business, our practice is unable to carry any outstanding balances. Any patients with outstanding balances over 90 days will be notified and if unresolved will be turned over to collections. If this happens, I agree to pay the collection cost of 25% and reasonable attorney fees incurred in attempting to collect on this amount or any further outstanding account balance.

Minor Child: Parent/Guardian bringing in the minor child accepts responsibility for all fees incurred.

Patient Name: _____

Our Insurance Policy

As a courtesy to you, our patients, we are happy to accept assignment of your insurance benefits and file your insurance claims for you. While we are pleased to offer this service, we are not responsible for any limitations in coverage that may be included in your plan. If your dental plan denies a claim for any reason or pays less than the estimated portion, you will then become responsible for paying that balance.

How do you want us to handle your insurance:

☐O'Loughlin Dental accepts assignment of benefits. We will submit your dental claims and receive the payment for the dental work done. Any portion that is not paid by your insurance carrier will be billed to you.

☐The patient accepts assignment of benefits and pays O'Loughlin Dental for the treatment rendered at the time of service. O'Loughlin Dental will submit the dental claims, and the payment for the work done will be sent directly to the patient. **This method entitles the patient to a 10% discount, excludes payment with Care Credit.**

Insurance Information

N

Subscriber: _____Is insured the patient? ☐Yes ☐No •If no, patient's

Relationship to the insured: _____ Insured's Birth Date: _____ SSN: _____

Address of Insured: _____
Street/PO Box City State Zip

Insured's Employer Name: _____ Phone: _____

Dental insurance company name: _____Phone #: _____ Address to

send claims: _____
Street/PO Box City State Zip

Payer ID: _____(Used to send claims electronically. They send payment faster with this.) Group #: _____

Please read and sign to have our office file your insurance: I authorize the release of information and understand that I am responsible for all costs of dental treatment. I hereby authorize payment directly to the below named dentist of the insurance benefits otherwise payable to me.

_____ Date: _____ Relationship to patient: _____

Signature of patient, parent or guardian