Esparza Family Dentistry

Patient Registration
(Please Print)

Date _____

Home Phone _____Work Phone _____Cell Phone _____

Patient Name _____
Last First Middle Int. Preferred Name

Address _____
Street City State Zip

Email Address_____ Age _____ DOB _____

Patient SS# _____ Marital Status S ___ M ___ D ___ W ___

Employer _____ Occupation _____

Primary Insurance

Name of Dental Insurance Co. _____

Member ID # _____ Group/Policy #_____

Guarantor's Name _____ SS# _____

Guarantor's Employment _____ Guarantor's DOB _____

Secondary Insurance

Name of Dental Insurance Co. _____

Member ID # _____ Group/Policy #_____

Guarantor's Name _____ SS# _____

Guarantor's Employment _____Guarantor's DOB_____

Emergency Contact _____
Name Phone Number

Whom should we thank for referring you? _____

I agree to be responsible for payment of all services rendered on my behalf or my dependents.
I understand dental insurance may pay less than the actual bill for services.

Signature of patient or parent, if minor _____

Relationship to Patient _____

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address: | **Today's Date:** | **Date of Last Visit:** | **Date of Med. History:**

City State Zip: | **Email:**

Home Phone: | **Work Phone:** | **Cell Phone:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

Primary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Secondary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks ☐
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke or use tobacco?

For Office Use Only
BP ☐ Heart Rate: ☐

Height: ☐
Weight: ☐

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Anemia
☐	☐	Sickle Cell Disease
☐	☐	Blood Transfusion
☐	☐	Hemophilia
☐	☐	Alcohol Abuse
☐	☐	Drug Abuse
☐	☐	Allergies
☐	☐	Sinus Problems
☐	☐	Artificial Heart Valve
☐	☐	Angina Pectoris
☐	☐	Congenital Heart Defect
☐	☐	Heart Attack
☐	☐	Heart Murmur
☐	☐	Heart Surgery
☐	☐	Mitral Valve Prolapse
☐	☐	Rheumatic Fever
☐	☐	Pace Maker
☐	☐	Joint Replacement
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	Emphysema

Y	N	Conditions
☐	☐	Tuberculosis
☐	☐	Cancer- Chemotherapy
☐	☐	Radiation Therapy
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Seizures
☐	☐	Fainting Spells
☐	☐	Frequent Headaches
☐	☐	Glaucoma
☐	☐	Fever Blisters
☐	☐	HIV+ AIDS
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	Liver Disease
☐	☐	High Cholesterol
☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure
☐	☐	Kidney Problems
☐	☐	Psychiatric Problems
☐	☐	Stroke
☐	☐	Thyroid Problems

Y	N	Conditions
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Pain In Jaw Joints
☐	☐	Past Or Recent Surgery
☐	☐	
☐	☐	

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

Esparza Family Dentistry

Financial Policy

Our office is committed to providing you with the highest quality dental treatment and the best possible care. We are happy to discuss our professional services and related fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. We encourage you to ask questions regarding fees, the office financial policy and your account status. You are responsible for all fees related to your treatment. You are responsible for the timely payment of your account. **We expect either payment in full or your co-payment on the day of service**. We will file your insurance as a courtesy to you. If your insurance company has not paid your claim within 45 days you will be notified. You will be expected to pay your balance at that time. After 60 days from time of service your account balance will accrue 1.5% interest monthly. After 90 days your account will be forwarded to our collection service. Collection fees, court cost, attorney fees and any other fees would be your responsibility. In cases of disputes, you agree that venue and jurisdiction for all matters concerning our relationship shall be proper only in the courts of the City of Virginia Beach, Virginia**.**
If you cancel your scheduled appointment within less than 24 hours notice, or fail to come to your appointment, a $26 per appointment hour charge will be incurred.

Insurance

This office is a participating provider with Delta Premier and United Concordia (please note: we are not contracted with United Concordia's Tricare Dental Program). It is very important that you understand your insurance benefit is a contract **between you and your insurance company**. We will gladly file your claim as a courtesy to you. However, you are ultimately responsible for any and all fees related to your dental treatment. **If your insurance company denies payment for a service deemed necessary by the dentist, we will do our best to appeal but you are ultimately responsible for payment of services rendered.** Any grievances or concerns regarding coverage and benefits should be directed to your employer or dental insurance provider. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges and benefits other than to supply factual information.
In cases where a secondary insurance is involved, you will be required to pay the portion of your account balance that was not covered by your primary insurance. **If you have 3 or more insurances, we will file the primary and secondary insurances only; we can give you the information you need to file any additional insurances you have.**
This office does not participate in HMO's or DMO's. It is imperative that you discuss your co-payment obligation prior to treatment. Due to the significant discount from our normal fee with certain insurance companies, your account must be paid in full on the date of service, per your insurance contract.

I have read the above financial policy and understand the provisions of the agreement. I have had an opportunity to ask questions and have them answered to my satisfaction. By signing this agreement, I accept the terms, provisions and obligations of the financial policy of this office.

Note: *In the case of default on payment of this account, I agree to pay collection costs and attorney fees of 33 1/3% incurred in attempting to collect on this outstanding account balance.*

Signature of patient/responsible party: _____ Date: _____

HIPAA CONSENT FORM
From the office of: Sarah T. Esparza, DDS, PC

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent by requesting a copy from the receptionist. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information (PHI) may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the use of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon execution of this Consent

Below is a list of ways the office may contact you. Checking a box will give permission to leave, as thorough of a message as needed, from your dental office. This will include, but not limited to, appointments day, time and treatment scheduled, documents to be signed, financial and collection concerns or pre and post treatment directions. Any source other than the USPS, example: cell phones, email and fax lines, are not considered 100% secure. Contact information will be verified by patient.

Please check any that you DO NOT want the office to call, we will be using the numbers/emails you have updated, on your Account information. All information is subject to availability to verify and validate.

__Work Cell	__Work Phone	__ Work Email	__Work Fax	__ Mail to Work
__ Personal Cell	__ Home Phone	__ Home Email	__ Home Fax	__Mail to Home
__Emerg. Contact	__Interpreter Contact			
__ **Any of the above**				

List names of who can have access to your dental/medical chart information: Circle Type.

State what part of your chart: Financial, Treatment, Health history, is allowed to be disclosed or copied

_____ **Full** access / **Partial** access _____

_____ **Full** access / **Partial** access _____

_____ Patient gives office permission to forward any verified contact information and PHI to patients specialists. Office may discuss pertinent patient chart information, including PHI, with labs, and product representatives involved in patient's case through verified unsecured, unencrypted means. The Privacy Rule allows those doctors, nurses, hospitals, laboratory technicians, and other health care providers that are covered entities to use or disclose protected health information, such as X-rays, laboratory and pathology reports, diagnoses, and other medical information for treatment purposes without the patient's authorization. This includes sharing the information to consult with other providers, including providers who are not covered entities, to treat a different patient, or to refer the patient. See 45 CFR 164.506. Any source other than your Healthcare Providers, will sign a Business Associate Agreement. Patient understands if permission is not granted, USPS, is the only means of communication with those involved in patients case, which is considered HIPAA compliant. Treatment may take considerably longer in this case. This office will not be held responsible for any delay in mail which then causes an increase in treatment time or treatment costs. Patients or approved contacts may request and pick up copies of PHI to be hand delivered.

Print Patient's Name: _____ **Date** _____

Print Legal Guardian's Name: _____ **Date** _____

Signature of Patient or Legal Guardian: _____ **Date** _____

____Patient refused to sign HIPAA Consent. Patient has the right to refuse. USPS or patient pick up will be used for PHI transfer.

Office Staff Signature_____ **Printed Name**_____ **Date** _____

Witnessed Staff Signature_____ **Printed Name**_____ **Date** _____