WILSON DENTAL, PC
EHR "ELECTRONIC HEALTH RECORD"

PLEASE PRINT

Patient's Name____

Date of Birth: _________________________________

Height: _________FT. ___________IN. Weight: _____________LB

To access your electronic dental records on our patient portal go to: **YourDentistOffice.com**

Email address: ____

Ethnicity/Race: *Please circle your answer*

ASIAN AMERICAN INDIAN/ALASKIAN NATIVE HISPANIC/LATINO

BLACK/AFRICAN AMERICAN WHITE/CAUCASIAN

OTHER: ________________________ DECLINE TO SPECIFY

Language: *Please circle your answer*

ENGLISH CHINESE MANDARIN SPANISH KURDISH ARABIC PORTUGUESE

JAPANESE RUSSIAN FRENCH GERMAN VIETNAMESE OTHER__________________

Smoking Status: *Please circle your answer*

NEVER SMOKED / FORMER SMOKER: AGE STARTED_______AGE QUIT______

CURRENT SMOKER: AGE STARTED ________ HEAVY / LIGHT OR MODERATE

Patient or legal guardian's Signature: ____

Date:___________________________________

Wilson Dental, PC

H.I.P.A.A. CONSENT & PHI

“PROTECTED HEALTH INFORMATION” FORMS

Name: ____

Please circle your answer

YES/NO May we contact you at home or work? Please list the phone # we can contact you:

Home /cell#: (___) ______-______Work#: (___) ______-______ ____.

YES/NO May we leave a message with a family member?

YES/NO May we mail you a letter or post card in regards to approvals, scheduling or billing?

Initial: __________

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of this office’s “Notice of Privacy Practices” & understand that I have the right to opt out of the following: Optional Information Disclosures: by initialing & signing this form you authorize us the consent to use and disclose the information in the manner that is described in the fore-mention notice provided to me.

Please circle your answer

YES/NO Telephone calls containing general information

YES/NO I authorize private dental information to be disclosed to my insurance company as requested.

YES/NO I authorize dental records and dental images/x-rays to be disclosed as considered necessary by my dental provider and this office.

Initial:__________

PHI AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This form is used to obtain authorization to disclose my health/dental information for the treatment and payment purposes to the individuals you designate below.

I give permission to Wilson Dental, PC to discuss and disclose my health/dental information to the individuals listed below to the extent necessary to help with my health/dental care or with my financial payments. I understand I may revoke this authorization in writing at any time.

Name: ___________________________________ Relationship: ___________________________

Name: ___________________________________ Relationship: ___________________________

Name: ____________________________________Relationship: ___________________________

Patient or legal guardian’s Signature: _________________________________ **Date**: ____________

Wilson Dental, PC
FINANCIAL POLICY

PATIENT NAME:_______________________________________ **DATE OF BIRTH**:____________________

PAYMENT: Fees for treatment are due in full and payable at time of service. For your convenience, we honor cash, check, and major credit cards: Discover, MC, Visa & Amer. Express, (HSA) health spending account cards with credit card logos.

INTEREST FREE LINE OF CREDIT: We also accept Care Credit financing which is an interest free line of credit you can apply for in office. You can also call: (800)-365-8295 or go online for an instant decision to: https://www.carecredit.com

MEDICAID & MANAGED CARE: Patients with Medicaid or MMC must present their ID card for eligibility verification and preauthorization before each appointment. You agree to be responsible for any services that you consent to be completed that are not approved or provided by Medicaid or managed care. For all such services payment will be due at time of service.

PAST DUE ACCOUNTS: If either of the above options results in your account becoming 30 days overdue, a finance charge of 1.5% per month will be applied to your account. Should your account be turned over to collection agency or attorney, a 25% collection fee will be added to your account in addition to any other collection fees, court costs, or attorney fees incurred. In case of suit, you agree the venue shall be in Broome County, New York. WAIVER OF CONFIDENTALTY: In any external collection action regarding tour account, your file may be a matter of public record.

RETURNED CHECKS: There is a minimum $25.00 charge for all returned checks. We may increase this fee anytime without prior notice due to bank fees and processing costs.

DENTAL INSURANCE: Insurance policies are contracts between the insurance company and you. It is the policy of your office to make financial arrangements with you directly, since you are responsible for treatment charges. Our office will process a completed insurance form for you to your insurance company. We assume responsibility for the amount of insurance coverage or process of reimbursements.

AUTHORIZATION FOR RELASE OF INFORMATION AND ASSIGNMENT OF BENEFITS:

I authorize Wilson Dental to release to my insurance carrier such protected health/dental information as may be necessary for the completion of my treatment claims, if necessary, assign to Wilson Dental benefits for such claims, and agree to be responsible for any balance remaining after payment of such claims. In consideration for the professional services rendered to me, or at my request, I agree and understand the above, and give my consent for services.

Patient or Legal Guardian's Signature: ____

Date:_________________________________

Wilson Dental, PC
APPOINTMENT CANCELLATION POLICY

POLICY: We have a 24 hour cancellation policy. If you need to change or reschedule an appointment with us, please give us at least ONE BUSINESS DAY notice. Our central scheduling center may be reached at: (607) 217-7123 between the hours of 8am-7pm Monday-Friday and 8am-5pm Saturday and Sundays.

MISSED APPOINTMENTS: If you have two consecutive missed appointments, or have three missed appointments within one year, we reserve the right to dismiss you from our practice. You will also be considered a no show if you cancel or reschedule after you arrive to your appointment.

MULTIPLE APPOINTMENTS: Patients that have multiple family members or multiple appointments on the same day that are cancelled or rescheduled without a 24 hour notice, may not be able to schedule on the same day or together again.

UNCONFIRMED APPOINMENTS: We reserve the right to cancel an appointment that has not been confirmed and ask that you update your contact information regularly.

LATE ARRIVAL: We have a 15 minute grace period for most appointments and if you are late for your appointment we reserve the right to reschedule your appointment for a later time.

Patient or Legal Guardian Signature: ___________________________________

Date:__________________________