JAMES MORELLI, DDS

Patient Information Form

WELCOME TO YOUR NEW DENTAL OFFICE – WE ARE PLEASED TO HELP YOU WITH YOUR CARE

Date ____________________________

Patient Name: First ______________________________________ MI______
Last ______________________________________ Nickname ________________________

Address: Street ____City
_________________________ State _______ Zip _______________________________

Phone: Home _____________________________ Work _______________________________
Mobile ___________________________

Social Security Number _____-_____-________ Date of Birth _______________________

Driver's License # __________________________________ State _______

Patient Employed By ____
Occupation _______________________________ Phone ____________________________

Address: Street ____
City ________________________ State _______ Zip ____________

Sex (circle): Male Female

Marital Status (circle): Married Single Divorced Separated Widowed

In case of emergency, whom shall be notified? _______________________________________

Relationship to Patient ______________________ Home Phone _________________________
Mobile__________________________________

Is the patient a Minor(circle)? Yes No

Name of Responsible Party: First ______________________ Last ________________________

Date of Birth ___________________________________

Relationship to Patient (circle): Self Spouse Parent Other _____________

Address: (if different from patient) Street ____
City ________________________ State _______ Zip ____________

Phone: Home ____________________________Work ___________________________
Mobile _____________________________

Employer (if different from above) ______________________________________
Occupation _______________________________ Phone ____________________________

Address: Street ____
City ________________________ State _______ Zip _______________

Dental Benefit Plan Information

1. Primary Dental Plan Name ____

Phone ____________________________

Address: Street ____City
_________________________ State________ Zip _______________

Name of Insured ____ Date of Birth
______________________________ ID Number ________________________

Policy Number ___________________________________

Patient Relationship to Insured _________________________________

2. Secondary Dental Plan Name ____

Phone ____________________________

Address: Street ____City
_________________________ State________ Zip _______________________________

Name of Insured ____Date of Birth
______________________________ ID Number ________________________

Policy Number ____

Patient Relationship to Insured ____

Cancellation Policy

Your appointment is reserved for your treatment and our doctor, hygienist, and staff are made available for you at the specific time reserved by you. We understand that unplanned issues arise, and you may need to cancel an appointment. If this occurs, we respectfully ask for scheduled appointments to be cancelled with a minimum of 24 hours in advance. This will allow for other individuals waiting to receive needed treatment to fill the space originally reserved for you.

If you cancel your scheduled appointment with less than 24 hours notice, a fee of $100.00 will be assessed.

I, ____, understand the above information and will comply with its contents regarding the cancellation policy.

Signature ______________________________________

Date ___________________________

Consent for Services and Financial Policy

Our financial policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.
All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. Our office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 10% per month on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for dental care can only be extended for a period of one month from the date of the patient treatment plan.

Consent

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due.

I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I also grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment. I have read and understand the office policy and consent for services:

Name (Printed): ______________________________

Date: ______________________________

Signature: ______________________________

HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This provides a safeguard to my privacy.

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. 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 health care 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 patient understands that:

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

Name (Printed): ____

Signature: ______________________________________

Date: _________________________

Representative Relationship to Patient (circle): Self Parent/Guardian Other ___________________