## Patient Information

**Name**: _____ **SSN**: _____ **Birthdate**: _____

**Sex**: ☐ M ☐ F **Marital status**: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed **Race**: _____ **Age**: _____

**Mailing address**: _____ **City**:_____ **State**:_____ **Zip**:_____

**Home phone**: _____ **Cell phone**: _____ **Work phone**: _____

**Email**: _____ **Preferred method of Contact:** ☐ Mail ☐ Email ☐ Phone

**Emergency Contact**: _____ **Phone**: _____ **Relation to Patient**: _____

**Who is responsible for your account and payment?** _____

**Address**: _____ **City**:_____ **State**:_____ **Zip**: _____

**Phone**: _____ **Email**: _____ **Birthdate**:_____

**Who is your General Dentist?** _____

**Pharmacy Name:** _____ **Pharmacy Phone:** _____

**Pharmacy Address:** _____

**How did you learn about Dr. Cherry/Dr. Reeder or whom may we thank for referring you?** _____

## Dental Insurance Information

Primary **Dental** Insurance Company: _____ Phone # _____

Subscriber: _____ Birthdate: _____ Subscriber's SSN: _____ Sex: ☐ M ☐ F

Policy ID # _____ Group # _____ Employer: _____

Authorization:
To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor of any changes. I authorize the use of my signature on all insurance submissions. Dr. Cherry or Dr. Reeder may use my health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefit payable for related services. Payment is due at the time of services unless prior arrangements have been made and approved. I understand that dental, health, and accident insurance policies are arrangements strictly between insurance carriers and subscribers and that if Dr. Cherry or Dr. Reeder files insurance preauthorizations and/or claims to these carriers on my behalf, it is solely as a courtesy to me. I agree to take full responsibility for the total amount of any services rendered including any discrepancies that may arise between initial insurance preauthorizations/estimates and subsequent insurance payments. If discrepancies do arise I agree to settle these directly with the respective insurance company. I agree to be responsible for all returned checks and legal or other fees incurred or levied by the practice in order to collect an overdue balance of mine.

**Patient/Guardian Signature:** _____ **Date:** _____

# HEALTH QUESTIONAIRE

Name (please print)_____ Age_____

**Please answer all questions by circling Yes (Y) or No (N)** **All responses are kept confidential.**

1. Y N Are you currently under a physician's care? If so, for what?_____
2. Y N Have you had any serious illnesses or operations? If so, please describe:_____
3. Y N Please list all medications, INCLUDING herbal supplements, you are currently taking:_____
4. Y N **Are you allergic to any medications or materials?** (Please list and describe reaction):_____
5. Y N Have you ever sought treatment for drug abuse and/or alcoholism?_____
6. Y N Do you have a heart murmur?_____
7. Y N Do you have Mitral Valve Prolapse?_____
8. Y N Have you ever had Rheumatic Fever or Rheumatic Heart Disease?_____
9. Y N Do you require antibiotics (SBE Prophylaxis) before treatment?_____
10. Y N Cardiovascular Disease (Heart Attack, Angina, Irregular Heart Rhythm, High or Low Blood Pressure, Stroke, Heart Surgery, Pacemaker?)_____
11. Y N Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath)?_____
12. Y N Seizures, Convulsions, Epilepsy, Fainting?_____
13. Y N Psychiatric or Emotional Problems, Anxiety Disorder, or Nervous Breakdown?_____
14. Y N Bleeding Disorder, Anemia, Bleeding Tendency, Bruise Easily?_____
15. Y N Liver Disease (Jaundice, Hepatitis)?_____
16. Y N Kidney Disease?_____
17. Y N Diabetes?_____
18. Y N Thyroid Disease (Goiter)?_____
19. Y N Arthritis?_____
20. Y N Osteoporosis?_____
21. Y N Stomach Ulcers or Colitis?_____
22. Y N Glaucoma?_____
23. Y N Implants placed anywhere in your body (heart valve, pacemaker, hip, knee)?_____
24. Y N Radiation treatment for cancer?_____
25. Y N Clicking or popping of the jaw joint, pain near ear, difficulty opening mouth, grinding or clenching of teeth?_____
26. Y N Any disease, drug or transplant operation that may have affected your immune system?_____
27. Y N HIV, AIDS or ARC?_____
28. Y N Recurrent sinus, urinary tract or other problems/infections of any kind?_____
29. Y N Do you smoke or chew tobacco? If so, how much per day?_____
30. Y N Do you use alcohol? If so, how much per day/week?_____
31. Y N Do you use cocaine, amphetamines, crack or any other street drugs?_____
32. Y N Do you have any other disease, condition or problem not listed above that you think the doctor should know about? If so, please explain:_____
33. Y N Do you wish to talk with the doctor privately about anything?_____

**Women Only**: Y N Are you pregnant or planning a pregnancy? Y N Are you taking birth control pills?
I understand that certain antibiotics may negate the action of birth controls pills and lead to undesired fertility. I have been informed to use alternative mechanical means of birth control while on any antibiotics prescribed by our office.
If you have questions, please consult with your physician for further guidance. _____ **Initials**

I understand a truthful history is important to the doctor. I certify that the above information is accurate to the best of my knowledge. _____ **Initials**

_____
Signature of Patient

_____ _____
Date Dr.'s Initials

# Stephanie Reeder, D.M.D., M.D
# James E. Cherry, D.M.D., P.A.
# Financial Policy

We are participating providers for the following Dental Insurance PPO Plans:

**Aetna Delta Cigna MetLife United Concordia**

We will file to the primary participating insurance plan for reimbursement to our office. You will be responsible for the primary insurance co-pay and deductible at the time of service.

We will be happy to assist you in filing to ***secondary*** and ***non-participating*** insurance plans for reimbursement directly to you; however, you will be required to pay the full balance at the time of service.

We accept the following forms of payment:

**Cash, Check, Visa, MasterCard, Discover, Amex, and CareCredit**

Treatment plans greater than $2500.00 may require a 50% deposit prior to scheduling a surgery date. This deposit will be required two weeks prior to the procedure to allow sufficient time for supplies to be ordered and received.

Account credits or balances of $30.00 or less will be written off after receipt of insurance payments unless specifically requested. Any balances overdue by 90 days with no payment will be turned over to a third-party collection agency.

I understand that dental, health and accident insurance plans are arrangements strictly between insurance carriers and subscribers and that if Stephanie Reeder, D.M.D., M.D files insurance preauthorization's and/or claims to these carriers on my behalf, it is solely as a courtesy to me. I understand that preauthorizations are not a guarantee of payment.

I agree to take full responsibility for the total amount of any services rendered including any discrepancies that may arise between initial insurance preauthorizations and subsequent insurance payments. If discrepancies do arise, I agree to settle these directly with the respective insurance company. Any insurance balances not paid within 60 days of treatment will become the patients' responsibility to pay.

I agree to be responsible for all returned checks, legal or other fees incurred or levied by the Practice in order to collect an overdue balance of mine. A fee of $30.00 will be charged for a returned check.

We require at least 24-hour notice if you need to reschedule or cancel your appointment so that we may give your allocated time to another patient. The first incident of a missed office appointment without 24 hours notification will be documented and the cancelation fee will be waived. If a second office appointment is missed without 24 hours notification a $50.00 fee will be charged and in order to schedule again you will be required to pay for your visit in advance.

Patient Signature: _____ Date: _____

# NOTICE OF PRIVACY PRACTICES

Patient's Name: _____

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

I give written consent for the following person(s) to access my medical records and appointment information on my behalf:

| _____ | _____ | _____ |
|---|---|---|
| Printed Name | Relationship to Patient | Phone Number |
| _____ | _____ | _____ |
| Printed Name | Relationship to Patient | Phone Number |
| _____ | _____ | _____ |
| Printed Name | Relationship to Patient | Phone Number |

*You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.*

_____ _____

**Patient's (or legal guardian) signature** **Date**