Patient Information

Name: _____ SSN: _____-_____-_____ Birthdate: _____ Age: _____

Sex Assigned at Birth: ☐ F ☐ M Current Gender Identity: ☐ F ☐ M ☐ FTM ☐ MTF ☐ Q ☐ Choose Not to Disclose

Pronoun Preference: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Choose Not to Disclose

Mailing Address: _____ City:_____ State:_____ Zip:_____

Cell phone: _____ Email: _____

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

Who is responsible for your account and payment? _____ Signature: _____

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

Phone: _____ Email: _____ Birthdate:_____

Who is your General Dentist? _____

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

Preferred pharmacy name and address: _____

Dental Insurance Information

Primary **Dental** Insurance Company: _____ Phone # _____
Subscriber: _____ Birthdate: _____
Subscriber's ID/SSN: _____

Medical Insurance Information

Primary **Medical** Insurance Company: _____ Phone # _____
Subscriber: _____ Birthdate: _____
Subscriber's ID/SSN:_____

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. 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. 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? Physician Name:_____
2. Y N Have you had any serious illnesses or operations?_____
   _____
   _____
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 Are you pregnant or planning a pregnancy? _____
6. Y N **Cardiovascular Disease** (Heart Attack, Angina, Irregular Heart Rhythm, High Blood Pressure, Stroke, Heart Surgery) _____
7. Y N Do you require antibiotics before dental treatment for a heart condition or a joint replacement?_____
8. Y N **Lung Disease** (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath)?_____
9. Y N Do you have **Sleep Apnea**? If so, do you wear **CPAP**? _____
10. Y N Seizures, Epilepsy, Neurological Disorders?_____
11. Y N Psychiatric Disorders? (Ex: Depression, Anxiety, Bipolar, etc)_____
12. Y N **Bleeding Disorder**, Anemia, Bleed or Bruise Easily?_____
13. Y N Liver Disease (Jaundice, Hepatitis)?_____
14. Y N Kidney Disease?_____
15. Y N **Diabetes**? If so, what is your most recent HgbA1c?_____
16. Y N Are you currently taking a **GLP-1 Medication**? (Ex: Semaglutide/Ozempic, Victoza, Trulicity) _____
17. Y N Thyroid Disease (Goiter)?_____
18. Y N Arthritis?_____
19. Y N **Osteoporosis**? If so, do you take medication for this?_____
20. Y N Reflux Disease, Stomach Ulcers or Colitis?_____
21. Y N **Bone or Blood cancers**? (Multiple Myeloma, Metastatic Breast or Prostate, Leukemia, Lymphoma)_____
22. Y N Implants placed anywhere in your body (heart valve, pacemaker, hip, knee)?_____
23. Y N **Radiation treatment for head and neck cancer**?_____
24. Y N Any disease, drug or transplant operation that may have affected your immune system?_____
25. Y N HIV, AIDS?_____
26. Y N Recurrent infections of any kind?_____
27. Y N Do you smoke or chew tobacco? If so, how much per day?_____
28. Y N Do you use marijuana, recreationally or medicinally? If so, how much per day?_____
29. Y N Do you use alcohol? If so, how much per day/week?_____
30. Y N Do you use any illegal drugs? (Ex: cocaine, heroin, meth, etc) _____
31. Y N Have you ever sought treatment for drug abuse and/or alcoholism?_____
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?_____

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

_____ _____ _____

Patient/Guardian Signature Date Doctor Initials

Stephanie Reeder, D.M.D., M.D
Financial Policy

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

Delta Cigna MetLife Ameritas

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 as well as filing any secondary insurance policy for reimbursement directly to you. **Please be aware that all treatment plans are ESTIMATES and not a guarantee of payment from insurance.**

Please be aware Dr. Reeder is not a participating provider with Medicare therefore we cannot file claims to Medicare or the secondary insurance. Patients with Medicare are responsible for all treatment fees in full at the time services are rendered.
Dr. Reeder is not a participating provider with any medical insurance. Patients will be responsible for all treatment fees at the time services are rendered. If the insurance is a PPO plan, our office is happy to file a courtesy claim so that your insurance may reimburse you directly.

We accept the following forms of payment:

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

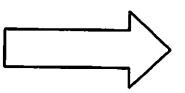
Treatment plans greater than $2500.00 may require a 50% deposit prior to scheduling a surgery date. This deposit will be required two weeks prior to the procedure to allow sufficient time for supplies to be ordered and received.
Any balances overdue by 90 days with no payment will be turned over to a 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. If an appointment is missed or rescheduled without 24 hours notification a $50.00 minimum deposit will be charged in order to schedule again and you may 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**