

# Welcome to a Brighter Morgantown!

New Patient Information



MORGANTOWN  
DENTAL GROUP



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EXCELLENCE IN DENTISTRY SINCE 1927

## Payment Options

# Welcome to a Brighter Morgantown!

Morgantown Dental Group would like to welcome you to the practice. We are committed to providing the best dental care for your particular needs. We will, however, only be able to accomplish this by spending the time necessary to diagnosis and treat your dental needs. This treatment is very important to your health and should not be postponed by financial concerns. We will gladly discuss your proposed dental treatment and answer any questions you might have. We appreciate the opportunity to serve you.

To enable you in proceeding without delay, our office offers several financial options. We encourage you to select a financial arrangement that works best in your budget. For your convenience, we offer the following financial arrangements for your dental treatment. Morgantown Dental Group wishes to make dentistry affordable to everyone and we hope you choose to make use your dental home.

## Payment Options

**We accept cash, check, Visa, Mastercard, and Discover.**

We gladly accept insurance, but require that the deductible and non-covered fees be paid at each visit. In the event of duplicate payment, your account will be credited or you can be reimbursed. If you have dental insurance, we will do our best to estimate your portion of the payment. This portion will be collected at the time of services. As a courtesy, we will file your insurance.

Alternate financing, such as Care Credit is accepted. We are happy to explain such financing and help you in filling out an application. Credit approval is required.

We gladly accept any patient regardless of their insurance provider. We are not, however, "preferred providers" for any particular insurance company. Payment for patients with this type of insurance is due at the time of service, and the insurance will reimburse the patient.

**DENTAL INSURANCE:**

I understand my dental insurance is a contract between the insurance carrier and myself, not between Morgantown Dental Group and the insurance carrier. As such, I understand that I am responsible for the full amount of all dental treatment incurred. Any payments received by Morgantown Dental Group from my insurance carrier will be credited to my account or refunded to me if I have paid the dental fees incurred.

**FINANCIAL RESPONSIBILITY:**

*I/We agree and personally guarantee, in consideration of services and materials provided by Morgantown Dental Group, to be responsible for payment in full of the dental bill. In the event that this matter is turned over to an attorney for collection, I/We agree that I/We shall pay twenty-five percent (25%) attorney's fees, interest on the unpaid principle balance at the right of eighteen percent (18%) per annum and all costs.*

Responsible Party's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_



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## Welcome to Our Practice

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can care for you.

## ABOUT YOU

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name: \_\_\_\_\_

(Last, First, MI)

Name I prefer: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ Social Security #: \_\_\_\_

Home Address: \_\_\_\_\_  
(Address, Street Apt/Condo#) (City) (State) (Zip)

Single  Married  Child

### CONTACT INFORMATION

Home Phone #: \_\_\_\_\_ Pager#: \_\_\_\_\_

Email address: \_\_\_\_\_

Work/EXT#: \_\_\_\_\_ EXT: \_\_\_\_\_

Employer:

Employer's Address: \_\_\_\_\_  
(Address, Street Apt/Condo#) (City) (State) (Zip)

Occupation: \_\_\_\_\_

Where & When is the best time to reach you? \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

In the event of an emergency, is there someone who lives near you that we should contact?  Yes  No

Their Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Work #: \_\_\_\_\_

Home #: \_\_\_\_\_

### NEW PATIENTS ONLY

Whom may we thank for referring you?: \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

Previous/Present Dentist: \_\_\_\_\_

Last Visit Date: \_\_\_\_\_

## PERSON RESPONSIBLE FOR ACCOUNT

Name: \_\_\_\_\_  
(Last, First, MI)

Name I prefer: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Home Address: \_\_\_\_\_  
(Address, Street Apt/Condo#) (City) (State) (Zip)

Are you currently under the care of a physician?  Yes  No

If No, Please Explain: \_\_\_\_\_

Employer: \_\_\_\_\_

## SPOUSE OR PARENTAL INFORMATION

Name: \_\_\_\_\_  
(Last, First, MI)

Employer: \_\_\_\_\_ Work/EXT#: \_\_\_\_\_

Home Phone #: \_\_\_\_\_

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

## DENTAL INSURANCE

### PRIMARY DENTAL INSURANCE

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: : \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Federal Employees R#: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Insured's Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Insured's Employer: \_\_\_\_\_

### SECONDARY DENTAL INSURANCE

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Federal Employees R#: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Insured's Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Insured's Employer: \_\_\_\_\_

## MEDICAL HISTORY

Do you have a personal a physician?  Yes  No

Physician's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date of Last Visit: \_\_\_\_\_

Are you currently under the care of a physician?  Yes  No

If No, Please Explain: \_\_\_\_\_

Do you smoke or use tobacco products?  Yes  No

Have you ever had any of the following diseases or medical problems?  Yes  No

YES  NO Heart Attack/Stroke

YES  NO Cancer/Chemotherapy

YES  NO Heart Murmur

YES  NO Heart Surgery/Pacemaker

YES  NO Mitral Valve Prolapse

YES  NO Artificial Bones/Joints

YES  NO Artificial Valves/Vascular Shunts

YES  NO Congenial Heart Defect

YES  NO Rheumatic Fever

YES  NO HIV+/AIDS

YES  NO Shingles

YES  NO Kidney Problems

YES  NO Sinus Problems

YES  NO High/Low Blood Pressure

YES  NO Thyroid Disease

YES  NO Severe/Frequent Headaches

YES  NO Psychiatric Problems

YES  NO Epilepsy/Seizures/Fainting Spells

YES  NO Diabetes/Tuberculosis (TB)

YES  NO Drug/Alcohol Abuse

YES  NO Venereal Disease

YES  NO Hemophilia/Abnormal Bleeding

YES  NO Ulcers/Colitis

YES  NO Anemia/Radiation Treatment

YES  NO Asthma/Arthritis

YES  NO Difficulty Breathing

YES  NO Hospitalized for any Reason

YES  NO Hepatitis

YES  NO Blood Transfusion

YES  NO Emphysema/Glaucoma

Please list any serious medical condition(s) that you have ever had: \_\_\_\_\_

List any medicine you are currently taking (including non-prescription medicines, vitamins, and herbal supplements): \_\_\_\_\_

Are you allergic to any of the following drugs?  Yes  No

YES  NO Penicillin

YES  NO Aspirin

YES  NO Erythromycin

YES  NO Tetracycline

YES  NO Dental Anesthetics

YES  NO Codeine

YES  NO Latex

YES  NO Other

Please list any other drugs that you are allergic to: \_\_\_\_\_

## FOR WOMEN ONLY

Are you taking birth control pills?  YES  NO Are you pregnant?  YES  NO

Week #: \_\_\_\_\_

Are you nursing?  YES  NO





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## Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Please review it carefully. The privacy of your health information is important to us.

### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (10/15/03), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

### USES AND DISCLOSURES OF HEALTH INFORMATION

**We use and disclose health information about you for treatment, payment, and healthcare options. For example:**

#### **Treatment**

We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

#### **Payment**

We may use and disclose your health information to obtain payment for services we provide to you.

#### **Healthcare Operations**

We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

#### **Your Authorization**

In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

#### **To Your Family & Friends**

We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that way me do so.

#### **Persons Involved in Care**

We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

#### **Marketing Health-Related Services**

We will not use your health information for marketing communications without your written authorization.

#### **Required by Law**

We may use or disclose your health information when we are required to do so by law.

#### **Abuse or Neglect**

We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

#### **National Security**

We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

#### **Appointment Reminders**

We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

### PATIENT RIGHTS

#### **Access**

You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$5.00 for each page, \$10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

#### **Disclosure Accounting**

You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14th, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

#### **Restriction**

You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

#### **Alternative Communication**

You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

#### **Amendment**

You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information would be amended). We may deny your request under certain circumstances.

#### **Electronic Notice**

If you receive this Notice on our Web site, or by electronic mail (e-mail), you are entitled to receive this Notice in written form.



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## Cancellation Policy

# Cancellation Policy

Morgantown Dental Group will make every effort to schedule you at a convenient time with an appropriate amount of time to allow quality treatment. Everyone's time is valuable and we will do our best to stay on schedule. To accomplish this, it is very important that you arrive on time for your appointment.

Please understand that short-term appointment changes and broken appointments, although occasionally unavoidable, are disruptive to your dental care and to the care of other patients. Therefore, we request notice as soon as possible if a scheduled appointment must be changed.

### **Our policy concerning canceled or broken appointments is as follows:**

A patient with an appointment must call at least 24 hours in advance prior to canceling or rescheduling their appointment time.

Same-day cancellations and/or rescheduling may result in a minimum fee of \$50.00, which will be billed directly to you.

With two short-notice appointment changes within a 12-month period of time, we will require you to hold your next appointment on a credit card.

After the THIRD cancellation or failed appointment within a 12-month period of time, we will request that you find the services of another dental office. At that point, we will remain available for 30 days on an emergency basis only.

I, \_\_\_\_\_ (print name of responsible party), understand this policy.

**Signature:** \_\_\_\_\_

**Witness:** \_\_\_\_\_

**Date:** \_\_\_\_\_

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES



\*YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT\*

I, \_\_\_\_\_, have received a copy of this office's  
Notice of Privacy Practices.

\_\_\_\_\_  
(Please print name)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

## FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify below)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_