Welcome!

Please take a few minutes to answer the following questions
so we can better assist you with your dental needs.

Patient Information

Date ______ Soc. Sec. # ______ Birthdate ______

Name ______ (Last Name, First Name, Initial) Home Phone ______

Address ______ Cell Phone ______

City ______ State ______ Zip ______ E-mail ______

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer ______ Business Phone ______

Business Address ______ Occupation ______

Who should we thank for referring you? ______

In case of emergency, who should we contact? ______ Phone ______

Primary Insurance

Person Responsible for Account ______ (Last Name, First Name, Initial)

Relationship to Patient ______ Birthdate ______ Soc. Sec. # ______

Address ______ Home Phone ______

City ______ State ______ Zip ______

Responsible Party Employed By ______ Business Phone ______

Business Address ______ Occupation ______

Insurance Company ______

Insurance Company Address ______

Subscriber I.D. # ______ Group # ______

Additional Insurance

Insured Name ______ (Last Name, First Name, Initial)

Relationship to Patient ______ Birthdate ______ Soc. Sec. # ______

Address ______ Home Phone ______

City ______ State ______ Zip ______

Insured Employed By ______ Business Phone ______

Insurance Company ______

Insurance Company Address ______

Subscriber I.D. # ______ Group # ______

Dental History

Former Dentist ______________________ Date of Last X-Rays ______________________

City, State ______________________ How Often Do You Floss? ______________________

Date of Last Dental Visit ______________________ How Often Do You Brush? ______________________

Please check all that apply:

- Bad Breath ☐
- Bleeding Gums ☐
- Blisters on Lips or Mouth ☐
- Finger Nail Biting ☐
- Grinding Teeth ☐
- Lip or Cheek Biting ☐
- Loose Teeth or Broken Fillings ☐
- Orthodontic Treatment ☐
- Pain Around Ear ☐
- Periodontal Treatment ☐
- Sensitivity to Cold ☐
- Sensitivity to Heat ☐
- Sensitivity to Sweets ☐
- Sensitivity When Biting ☐
- Frequent Headaches ☐
- Jaw, Head or Neck Injuries ☐
- Jaw Difficulty: Clicking and/or Pain.. ☐
- Tooth Pain ☐

Medical History

Physicianís Name ______________________ Date of Last Visit ______________________

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Are you currently taking any medication?	☐	☐

Please describe: ______________________

____

	Yes	No
4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Do you wear contact lenses?	☐	☐

7. Have you had any allergic reactions to the following:

	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. (Women Only) Are You:

	Yes	No
Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

- AIDS ☐
- Anemia ☐
- Arthritis, Rheumatism ☐
- Artificial Heart Valves ☐
- Artificial Joints ☐
- Asthma ☐
- Back Problems ☐
- Bleeding abnormally, with extractions or surgery ☐
- Blood Disease ☐
- Cancer ☐
- Chemical Dependency ☐
- Chemotherapy ☐
- Chronic Fatigue Syndrome ☐
- Circulatory Problems ☐
- Congenital Heart Lesions ☐
- Cortisone Treatments ☐
- Cough - persistent or bloody ☐
- Diabetes ☐
- Emphysema ☐
- Epilepsy ☐
- Fainting or Dizziness ☐
- Glaucoma ☐
- Headaches ☐
- Heart Murmur ☐
- Heart Problems ☐
- Hepatitis-Type ______ ☐
- Herpes ☐
- High Blood Pressure ☐
- HIV Positive ☐
- Jaundice ☐
- Jaw Pain ☐
- Kidney Disease ☐
- Latex Sensitivity ☐
- Liver Disease ☐
- Low Blood Pressure ☐
- Mitral Valve Prolapse ☐
- Nervous Problems ☐
- Pacemaker ☐
- Psychiatric Care ☐
- Radiation Treatment ☐
- Respiratory Disease ☐
- Rheumatic Fever ☐
- Scarlet Fever ☐
- Shortness of Breath ☐
- Sinus Trouble ☐
- Skin Rash ☐
- Stroke ☐
- Swelling of Feet/Ankles ☐
- Swollen Neck Glands ☐
- Thyroid Problems ☐
- Tonsillitis ☐
- Tuberculosis ☐
- Tumor or growth on head/neck ☐
- Ulcer ☐
- Venereal Disease ☐

Assignment and Release

I hereby authorize payment directly to ______________________ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party ______________________ Date ______________________

Financial Agreement

We, the staff of **Dr George T Philip DMD** thank you for choosing us as your dental/health provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities please feel free to contact the office at 972-285-6144.

We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our Financial Coordinator.

We make payment as convenient as possible by accepting (cash, money order, MasterCard, Visa, American Express and in-state checks). A $35.00 service fee will be charged for all returned checks. Additionally, you may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

Interest

Interest will incur if a balance remains unpaid after 60 days.

Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are

contractually obligated to collect co-payments, co-insurance, and deductibles, as outlined by your insurance carrier.

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier we will not negotiate reduced fees with your carrier.

Missed Appointments

We require notice of cancellations 48 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance: a missed appointment fee will apply. These fees are typically $50.00. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

Medical Records Fees

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines, and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor, and postage of the files, and or summaries.

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

Timeliness of Appointments

We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule you if necessary.

I have read and understand the above financial policy. I agree to assign insurance benefits to whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

Signature of Insured or Authorized Representative: ______________________________

Date: ____________________

Assignments of Benefits Form

Practice Name: Dr George T Philip DMD
Address: 2858 N Beltline Rd # 300
City State Zip: Sunnyvale TX 75182
Phone: 972-285-6144

Date: ______________________
Patient: ______________________
ID# : ______________________
Group#: ______________________

I, ______________________(**patients name**), understand that services rendered to me by **Dr George T Philip DMD** are my financial responsibility and that the Provider will bill my ______________________(**insurance company**) as a courtesy. I authorize my insurance company to pay my benefits directly to **Dr George T Philip DMD** and I understand that I will be fully responsible for any outstanding balance on my account. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state and federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by ______________________(**insurance company**).

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim. I also authorize provider to initiate a complaint to the insurance commissioner for any reason on my behalf.

I also understand that should my insurance company send payment to me, I will forward the payment to **Dr George T Philip DMD** within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any costs incurred by the office to retrieve their monies. In the event Patient receives any check, draft, or other payment subject to this Agreement, I will immediately deliver said check, draft, or payment to Provider. Any violations of this Agreement will, at Provider's election, terminate Patient charge privileges with Provider and bring any balance owed by Patient to Provider immediately due and payable.

To avoid this additional cost and inconvenience, should the insurance company forward the payment to me, I authorize **Dr George T Philip DMD** to facilitate payment utilizing the credit card number on file to resolve the balance.

Signature of Policyholder: ______________________

Guardian/Patient Print Name: ______________________

Date: ______________________

Witness: ______________________

Dr George T Philip DMD

Consent for Use and Disclosure of Health Information

Section A: Patient Giving Consent

Name: ______________________________

Address: ______________________________

Social Security: ______________________________

Section B: To the Patient, please read the following statement carefully...

Purpose of Consent: By whether printing and signing this form, or submitting this form electronically, you consent to our use and disclosure of your protected health and information to carry out treatment, payment activities and health care operations.

Notice of Privacy Practices: You have the right to read our **NOTICE OF PRIVACY PRACTICES** before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and health care operations of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our notice is available. We encourage you to read the information carefully and completely.

We reserve the right to change our Privacy Practices as described in our Notice of Privacy Practices. If we change our Privacy Practices, we will issue a Revised Notice of Privacy Practices.

Contact Person:

Dr George T Philip DMD
2858 N Beltline Rd #300
Sunnyvale Texas 75182
Phone: 972-285-6144
Fax: 972-285-3434

I ______________________ **(print patient name)** have had full opportunity to read and consider the contents of this Consent Form. I understand that, by signing this Consent Form, I am giving my consent to your Use and Disclosure of Health Information to carry out treatment, payment activities, and health care operations.

Signature: ______________________ **Date:** ______/______/______

If a Personal Representative, on behalf of the Patient, signs this consent form please complete the following.

Personal Representative's Name: ______________________ **Date:** ______/______/______

Assignments and Release: I ______________________ **(print patient name)** am well aware that payment is due at the time services are rendered. I understand that I will owe an additional $35.00 return check fee, should I decide to pay with a check. I hereby authorize my insurance payments /benefits be directly sent to the office of Dr George T Philip DMD. I understand that I am financially responsible for any balance remaining on my account even though the insurance company has paid their considered portions/estimates. I also authorize my records be released to the insurance company for payments.

I have read and fully understand the FINANCIAL POLICY set forth by Dr George T Philip DMD. I agree that if it becomes necessary to forward my account to a collection agency, I will also be responsible for the fee charged by the agency for the costs of collection in addition to the original amount due.

Signature of Patient/Guardian/Responsible Party: ______________________

Date: ______/______/______

Appointments

Cancellations, Rescheduling, and NO SHOWS

We set aside dedicated time in our office for your dental needs. If you find it necessary to cancel or reschedule, please call the office 48 hours in advance. Appointment reminders are being made via email, text, or/and by phone so we are requesting that you contact us with confirmation otherwise your appointment time will be released. We are aware and understand that things come up unexpectedly, however, other patients can find that time valuable. Without proper notice, you will be charged a $50.00 (dollar) fee. For any late arrivals, you will be re-scheduled and charged the $50.00 (dollar) fee as well.

______________________________	______________________________
Print Patient Name	Date of Birth
______________________________	______________________________
Guardian/Patient Signature	Date