High Tide DENTAL

Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Cell): _____ (Work): _____

Email: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Medical History Information

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV
☐ Allergies _____ _____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Bisphoshate History
☐ Blood Disease
☐ Cancer/Chemo
☐ Dental Anxiety
☐ Diabetes
☐ Drug Addiction
☐ Excessive Bleeding
☐ Fainting
☐ GI Problems
☐ Glaucoma
☐ Head Injuries
☐ Heart Disease
☐ Heart Condition
☐ Heart Valve Replacement
☐ Hepatitis
☐ High Blood Pressure
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date: _____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Seizure
☐ Sinus Problems
☐ Stroke
☐ Tuberculosis
☐ Ulcers

OTHER:
☐ _____

☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of PCP: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

Current Medications:

_____
_____
_____
_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

High Tide DENTAL

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for account payments

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Cell): _____ (Work): _____

Email: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Emergency Contact

☐ Patient's spouse, see contact information above

Name: _____

☐ Male ☐ Female

Phone (Home): _____ (Cell): _____ (Work): _____

Email: _____

Address: _____

Street Apartment #

_____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

High Tide DENTAL

CONSENT TO TREAT & RADIOGRAPH CONSENT FORM

● I hereby authorize Dr. Homicz or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate and mutually agreed upon by the doctor to make a thorough diagnosis of:

(Name of Patient) _____'s dental needs.

● Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper dental care.

● I agree to the use of anesthetic, sedative and other medications as necessary. I fully understand that using anesthetic agents embodies certain risk. I understand that I can ask for a complete recital of any possible complications.

Dr. Homicz recommends a full mouth series of radiographs be taken on adults every 3-5 years and bitewing radiographs every 12-18 months. Our radiographs produce a minimal amount of radiation but provide valuable diagnostic information and early detection of cavities, periodontal disease, cysts, abscesses, tumors and other severe pathology.

Please inform us if you are pregnant, had head or neck radiation therapy, or been advised by a physician to avoid dental radiographs.

OFFICE FINANCIAL POLICY

Payment is due at the time services are rendered. For your convenience we accept cash, checks, Visa, MasterCard, money orders or registered checks. *Care Credit* may also be available to you. Checks that are returned to our office from your financial institution are subject to a $25.00 returned check fee. This fee covers the processing fees that are charged to our office.

Insurance benefits are determined by your employer, not your dentist. Your insurance policy is a contract between you and your insurance company. Your insurance coverage and benefits are your responsibility. Insurance is not a guarantee of payment; it often does not cover all the costs involved in treatment. As a courtesy, we will be happy to file your claim for you if you present your dental insurance wallet card and all required employer information. You will be expected to pay for services rendered if this office is unable to verify your insurance information before treatment.

Any deductible or estimated co-payment amount will be due at the time of treatment. If payment for services already rendered has not been paid in full within 30 days, either by you or your insurance company, the remaining balance for your treatment is considered due and must be paid by you. Account balances over thirty days will be charged interest at a rate of 1.5% per month.

Appointments are reserved exclusively for you. As a benefit to you, our valued patient, we may offer to move your appointment to an earlier time if an opening arises. If an appointment is not canceled at least 24 hours in advance, or if you fail to keep your appointment, you will be charged a fifty-dollar ($50) fee. This fee will not be covered by your insurance company.

I have read and understand this financial policy.

Patient's Signature _____ Date _____

Witness _____

Parent/Responsible Party's Signature_____

High Tide DENTAL

Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights regarding my health information. I acknowledge that Dr. Lucas Homicz has provided me with the information on how High Tide Dental, PA will maintain the privacy of my health care information, my patient rights, and his office privacy practice.

I understand that this information may be used to:

- coordinate and direct my dental treatment
- treatment plan among multiple dental & healthcare providers who may be involved directly or indirectly involved in my treatment
- obtain payment from third-parties, i.e. insurance companies

I acknowledge that I have received High Tide Dental, PA's Notice of Privacy Practices containing a more detailed disclosure of the uses of my health records and information. I have had the opportunity to ask questions to either Dr. Homicz or his staff. I understand that High Tide Dental, PA has the right to change its Notice of Privacy Practices from time to time and that I may contact High Tide Dental to obtain a current copy of the Notice of Privacy Practices at any time.

I understand that I may request in writing to have my dental records and healthcare information restricted for privacy purposes.

Date:_____

Patient Name: _____ DOB: _____

Signature:_____

Staff Witness:_____