MA Dental Care

Cosmetic & Family Dentistry

2 Haven Street Suite 303 Reading MA 01867

staff@madentalcare.com

(781) 944-4240

Name: _____ Sex: ____ M ____F

Date of Birth: _____ Home Phone:_____ Cell Phone: _____

Email Address: _____

Home Address: _____City: _____ Zip Code: _____

Drivers License Number: _____ State: _____ SS#: _____-____-_____

Employer Information

Employer Name and Address: _____

Employer Phone: _____

Spouse's Name: _____ Work Phone: _____

Social Security #: _____ Date of Birth: _____

Nearest relative not living with you: _____ Phone: _____

Nearest friend not living with you: _____ Phone: _____

Primary Care or Referring Physician: _____ Phone: _____

Previous Dentist: _____ Phone: _____

Whom may we contact in the case of an emergency?_____ Phone: _____

Whom may we thank for referring you to us?_____ Phone: _____

Who is responsible for this bill? _____

Insurance Information

Name of Insured: _____ Relationship to Patient: _____

Birthdate: _____ Social Security Number: _____

Name of employer: _____ Office Phone: _____

Insurance Company: _____ Group #:_____ Employer/ID# _____

Insurance company address: _____ City/State: _____ Zip: _____

Do you have Secondary Insurance? ___Yes ___No

Name of Insured: _____Relationship to Patient: _____

Birthdate: _____ Social Security Number: _____

Name of employer: _____ Office Phone: _____

Insurance Company: _____ Group #: _____ Employer/ID# _____

Insurance company address: _____ City/State: _____ Zip: _____

If this claim is accident related, please provide details of the accident: _____

Did you sustain an injury at work?

□Yes □No

Are you covered under an employer or union policy?

□Yes □No

Are your injuries accident related?

□Yes □No

Is your spouse or other family member employed?

□Yes □No

Are you currently employed?

□Yes □No

Do you have a secondary or medical insurance policy?

□Yes □No

Have you ever served in the military?

□Yes □No

Are you covered under any other healthcare plan?

□Yes □No If so Name and #_____

Medical History: Do you have or had any of the following (Please circle)

AIDS	Diabetes	Pacemaker
Anemia	Epilepsy	Psychiatric Care/Problems
Arthritis/Rheumatism	Fainting	Radiation Treatment
Artificial Heart Valves	Glaucoma	Respiratory Disease
Artificial Joints	Headaches	Rheumatic Fever
Asthma	Heart Murmur	Shortness of Breath
Back Problems	Heart Attack	Skin Rash
Bleeding Abnormalities	Heart Problems	Sinus Problems
Blood Disease	Hemophilia	Stroke
Cancer	Hepatitis	Thyroid Problems
Chemical Dependency	High Blood Pressure	Tobacco Habit
Chemotherapy	HIV	Positive Tuberculosis
Circulatory problems	Kidney Disease	
Congenital Heart Lesions	Liver Disease	
Cortisone Treatments	Mitral Valve Prolapse	

Are there any other health conditions you have that are not listed?
If so, please explain: _____

Please List all Allergies: _____
Please List all Medications You are Taking:
_____

Women Only:
Are you Pregnant? __ Yes __ No Nursing? __ Yes __No Had an exposure to HPV? __ Yes __No

Date of Last Dental Exam: _____ Reason for Today's Visit: _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information. **This information will be kept confidential.**

_____ _____
Signature Date

Dr._____ _____
Reviewed By Date

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Welcome to our practice. We, the staff of MA Dental Care , 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 our office at (781) 944-4240.

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 staff.

We make payment as convenient as possible by accepting (cash, money order, MasterCard, Visa 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 of 18% will incur if a balance remans 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.

Miscellaneous Forms, Additional Information and Authorizations

We will provide all necessary information to have your benefits released. However, if it becomes necessary to submit redundant or unnecessary information for the completion of claim forms for school, sports or extra curricular activities there will be an administrative fee, not to exceed $35.00, for the additional information.

Missed Appointments

We require notice of cancellations 24 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 $35.00 but not to exceed one-half of the cost of your scheduled appointment. 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: _____