Nemetz Dental Associates

SPECIALTY DENTAL CARE FOR THE ENTIRE FAMILY

Pediatric Dentistry • Adult Dentistry • Periodontics • Prosthodontics

ROBERT J. NEMETZ, D.D.S., M.S.

PERIODONTICS, PROSTHODONTICS & ADULT DENTISTRY

904-886-GUMS (4867) FAX: 904-292-2205

PATIENT REGISTRATION INFORMATION:

Correct answers to the following questions will allow us to treat you on an individual basis, providing the care appropriate for your particular needs. Check yes or no, whichever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

Date: _____

Mr./ Mrs./ Ms.

_____/_____/_____/_____

Last First Initial Name Preferred

Street Address: _____

City: _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

E-mail Address _____

Soc. Sec. # _____ Birth Date _____ Marital Status _____ Sex _____

Employer Name _____ Occupation _____

Were you referred by another dentist, dental professional, friend, etc.? _____

EMERGENCY INFORMATION:

In case of emergency contact:

Name _____ Relationship _____

Contact Phone#: _____

MEDICAL INFORMATION:	**YES**	**NO**
1. Has there been any change in your general health within the past year? _____	☐	☐
2. My last physical examination was on _____		
3. The name and address of my physician is _____		
_____		
4. Have you had any serious illness or hospitalizations within the past five (5) years _____	☐	☐
If so, please explain _____		
5. Pharmacy Phone Number: _____		

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Patient Medical History Continued

Do you have or have you ever had any of the following:

	Yes	No		Yes	No
Aids () HIV Infection()	☐	☐	Hepatitis () Jaundice () Liver Disease ()	☐	☐
Anemia	☐	☐	High Blood Pressure() Low Blood Pressure()	☐	☐
Angina	☐	☐	Joint Replacement() Implant()	☐	☐
Arthritis () Rheumatism()	☐	☐	Kidney Trouble	☐	☐
Artificial() Replacement valves()	☐	☐	Pacemaker	☐	☐
Asthma or Hay fever	☐	☐	Rheumatic fever	☐	☐
Chest Pain	☐	☐	Rheumatic heart disease	☐	☐
Diabetes	☐	☐	Seizures	☐	☐
Digestive system - ulcers() colitis()	☐	☐	Sinus trouble	☐	☐
Fainting() Dizzy Spells()	☐	☐	Tuberculosis	☐	☐
Heart defect() or Heart Murmur()	☐	☐	Do you use any tobacco products	☐	☐
Have you ever required a blood Transfusion?	☐	☐	Have you had abnormal bleeding associated with previous Extractions, surgery, or trauma	☐	☐

If so explain the circumstances and when

_____

_____

_____

Woman

Are You Pregnant?	☐	☐
Are You Taking Birth Control?	☐	☐

Are you taking any of the following (if yes state drug name and dosage)

Antibiotics	☐	☐	Heart Medications	☐	☐
Anticoagulants (Blood Thinners)	☐	☐	Insulin	☐	☐
Antistamies	☐	☐	Medicine for High Blood Pressure	☐	☐
Aspirin	☐	☐	Tranqulizers	☐	☐
Cortisone (steroids)	☐	☐	Other Medications	☐	☐

Are you allergic or have you reacted adversely to any of the following

Aspirin	☐	☐	Latex() other Rubber products()	☐	☐
Barbiturates() Sedative() or sleeping Pills()	☐	☐	Local Anesthetics	☐	☐
Codeine(), Demerol(), Or other Narcotics()	☐	☐	Penicillin() Other Antibiotics()	☐	☐
Iodine	☐	☐	Other	☐	☐

Is there anything of importance in you medical history that has not been asked? ☐ ☐

_____

_____

_____

_____

_____

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Dental History

	Yes	No
Are you having any discomfort at this time?----------	☐	☐
If so where?_____		
Have you been Please with your previous dental treatment?----------	☐	☐

Does your dental treatment make you nervous? ☐No ☐Slightly ☐Moderately ☐Extremely

Date of last dental visit:_____

Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)	☐	☐

If so, when:_____

Do you have or have you ever had any of the following?

Mouth	Yes	No
Bleeding, sore gums	☐	☐
Unpleasant taste/ bad breath	☐	☐
Burning Tongue / lips	☐	☐
Frequent blisters, lips/mouth	☐	☐
Swelling / lumps in mouth	☐	☐
Ortho Treatment (braces)	☐	☐
Clicking / popping jaw	☐	☐
Difficulty opening or closing jaw	☐	☐

Teeth	Yes	No
Loose Teeth	☐	☐
Sensitive to hot	☐	☐
Sensitive to cold	☐	☐
Sensitive to sweets	☐	☐
Sensitive to biting	☐	☐
Food impaction	☐	☐
Clenching or grinding	☐	☐
If so when?		

_____

Describe the condition or problem's for which you are seeking Treatment

_____

_____

Doctors Notes:

_____

_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever any change in my health or change in my medication, I will inform the dentist at the next appointment.

_____ _____

Signature of patient Date Signature of Dentist Date

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INSURANCE AND BILLING

Billing Policy: Payment is due when services are rendered.

Dental Insurance Policy: A complete and signed insurance form is necessary to file an insurance claim. As a courtesy, we will file most dental insurance claims for you. Some insurance companies, however, do not reimburse our office in a timely manner. In some cases, we may ask you to file the insurance claim. You would then pay for the treatment on the day of service and the insurance company will reimburse you after the claim has been sent. We do not file secondary insurance claims.

Person Responsible for Account

() Same as above- Name: _____ Birth Date: ___/___/____Relation; _____

Billing Address: _____ City: _____State_____Zip_____

Home Phone :(___) _____Work (___) _____Cell:(___)_____

Social Security #:_____ Employer: _____

Dental Insurance

Primary Insurance

Insurance Company: _____ Phone (____) _____

Insured's Name: _____ Insured's DOB: ___/___/____Relation:_____

Insured's ID or SS#:_____ Group#_____

Insured's Employer: _____

Secondary Insurance

Insurance Company: _____ Phone (____) _____

Insured's Name: _____ Insured's DOB: ___/___/____Relation:_____

Insured's ID or SS#:_____ Group#_____

Insured's Employer: _____

Diagnosis of services needed and financial obligations will be discussed with you by the doctor and/or staff before treatment is rendered.
The undersigned also agrees to be responsible for any bill incurred for dental treatment. I certify the information provided is correct, and I give my consent to Dr. Nemetz to send a copy of my dental records to my insurance company, a referring dentist or physician and to perform a credit check if necessary.

NAME _____ DATE _____

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NEMETZ DENTAL ASSOCIATES, INC.
FINANCIAL POLICY FOR PATIENT'S AND DEPENDANTS

This financial policy is provided to help you understand the financial aspects of your visit to our office. Dentistry is no different than any other service oriented business. Payment is due when services are rendered. We do not participate with all insurance companies. If you provide us with your current insurance information, we will file claims to your primary insurance carrier for you. *This office will not file your secondary insurance. We will provide you with claim forms, if necessary, that you can use to file a claim to your secondary insurance.* We can provide you with a written estimate for any planned dental procedures. This estimate will include the anticipated procedures needed and the cost of those procedures. The written estimate will show you an approximate breakdown of how your insurance company may apply your dental benefits to the planned treatment. This estimate may change after the treatment begins based upon the clinical findings of the doctor during the course of care. Please keep in mind, that the estimate includes only approximate figures and we cannot exactly predict how your insurance company will reimburse for each procedure. The fees listed on the estimate are good for 120 days and are subject to change thereafter. **You are ultimately 100% responsible for the entire amount of any treatment completed if your insurance company fails to pay their portion of this estimate.** Communication between you and your insurance company is highly encouraged to ensure timely insurance processing and payment. During the course of dental care at this office, if you sign up with a different dental insurance carrier with your employer you may incur additional charges at this office depending on your benefits. It is important for all patients to understand the terms and conditions of their insurance policies. Unlike medical insurance, most dental insurance companies have annual maximum benefits that significantly limit the amount of dental coverage especially if your dental needs are extensive. If your dental needs exceed your annual maximum benefits, you will be financially responsible for the remaining balance.

We have excellent relationships with many insurance companies but we have no way of knowing any limits you may have reached or any remaining balances that will be applied towards your deductible. Some insurance companies may deny benefits for routine dental procedures. **If there is a problem with one of your claims, we will do everything possible to get your insurance company to pay their portion of the claim.** If they continue to deny the claim, you will be responsible for payment of the entire amount. Please remember, your employer customizes insurance plans and they may limit certain items such as frequency of exams, x-rays or certain types of restorations. It is important for you to understand what your plan will pay. We will do everything we can to make sure your insurance company has accurate information they need to process your claim. However, please remember that we are not responsible for denied claims or restrictions of your insurance benefits. You will be responsible for any remaining balance that is not covered by your insurance company. By filing your insurance, we are extending credit to you from the time treatment begins to the time the insurance payment is received. Generally, this may be up to 60 days. However, if after 60 days ,from the date of service, your insurance company has not paid your claim, we will forward the unpaid balance directly to you for payment. Rebilling charges will begin to accrue at 90 days on unpaid balances, at the rate of 1.5% per month until paid in full.

Any **long-standing unpaid balance** that has not been paid by the patient or by the dental insurance company will be sent to a collection agency. Along with interest charges, additional surcharges of up to 35% of the total unpaid balance plus collection agency processing fees will be added to your balance. You are responsible for any collection agency or legal fees associated with the collection of an unpaid balance. To avoid this collection process, please pay off your balance promptly. Please understand that in order for us to file your insurance and to provide services in advance of payment, we must set these policies. We value you as a patient and look forward to a long-term and rewarding relationship.

If you do not have dental insurance, payment is expected when dental services are rendered. **A low interest third party credit payment plan is available to qualifying patients.** Please ask one of our office staff to assist you with this simple application process.

I have read the above information and understand that I am responsible for any unpaid balance for services provided to my dependent or me.

_____ _____

Signature **Date**

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AUTHORIZATION FOR DENTAL TREATMENT, RELEASE of MEDICAL OR DENTAL INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS AND BROKEN APPOINTMENT POLICY

CONSENT FOR TREATMENT: I hereby authorize Dr. Nemetz or any doctor associated with this practice, to perform any diagnostic, preventative, restorative, major and surgical procedures and to administer medications and anesthetics as their best professional judgment deems necessary and proper in the treatment of the patient. The benefits and risks of certain procedures will be thoroughly explained to you prior to being done along with alternatives and options, if any, will be discussed. You will be given additional information and written consents for more complicated procedures. I agree to the use of local anesthesia with or without sedation, depending on the judgment of the doctors in my care with my preference taken into consideration. I understand the potential complications which may result from dental therapy, anesthesia or medications administered or prescribed by the doctor. These include but are not limited to: pain, swelling, bleeding, bruising, infection and numbness and/or tingling or altered sensation in lips, tongue, gums, teeth, chin, cheeks or other areas which may in some cases persist, or rarely, be permanent. Other complications include pain and/or swelling at the site of an injection, injury to teeth and/or fillings in the area where treatment or anesthetic is being done, delayed healing, reactions to medications including allergy, nausea, vomiting, diarrhea or atypical reactions. Any of these could require additional treatment. In addition, medications administered or prescribed by the doctor can cause drowsiness and/or lack of coordination. I agree to follow the advice of my doctor and his staff regarding the operation of a motor vehicle or hazardous machinery, or any other activity restrictions recommended for a postoperative period. I understand that there is no guarantee of a result or cure. I know that I may ask any questions about the treatment prior to its being done, and may have alternatives, options, risks, benefits and potential complications reviewed for me at any time prior to proposed treatment.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Dr. Nemetz or any doctor associated with him, to release information pertaining to my (or my child's) dental care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits or a credit review.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment of insurance benefits directly to Dr. Nemetz or any doctor associated with him and hereby assign any and all insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services or what was estimated by Dr. Nemetz's staff. I understand that I am solely financially responsible for payment in full of all accounts. By signing this statement, l revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental insurance carrier. I further understand that insurance is filed as a courtesy to me.

BROKEN APPOINTMENT POLICY: It is our policy to charge for a broken appointment. A broken appointment is defined as a failure by the patient to give our office 24 hours notice in advance to cancel a scheduled appointment. For broken exam appointments there will be a $50 charge. For longer broken appointments of 1 hour or greater, the charge will be at a rate of $150.00 per hour and must be paid prior to making future appointments. I hereby authorize Dr. Nemetz and any doctor associated with him to charge for a broken appointment.

Signature:_____ **Date:**_____

PAYMENT IN FULL IS EXPECTED AT THE TIME SERVICES ARE RENDERED, UNLESS ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name: _____

Address: _____

Telephone: _____ **E-Mail Address:** _____

Social Security #: _____

SECTION B: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare 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 healthcare 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 accompanies this Consent at our office. We encourage you to read it carefully and completely before signing this Consent. 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, which will contain the changes. Those Changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Telephone: (904) 886-4867 Fax: (904) 292-2205
Address: 12421 San Jose Blvd. Suite 320 Jacksonville, FL 32223

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that the revocation of this Consent **will** not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature:
I,_____ have had full opportunity to read and consider this consent
Patient Name

form and the Notice of Privacy Practices. I understand that by signing this Consent form I am giving my consent for the use and disclosure of my protected health information and to carry out treatment, payment activities and health care operations.

Signature: _____

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ACKNOWLEDGEMENT OF RECEIPT OF OFFICE PRIVACY PRACTICES

The undersigned acknowledges Nemetz Dental Associates, Inc., Notice of Privacy Practices (HIPPA) this day of _____, 20_____. If you wish to read the Federal Privacy Act, a copy is available at the reception desk.

_____

Print your name

_____

Sign your name

If you are the legal representative of the patient, please print the patient's name(s) and describe your authority: _____

Anyone else that we may speak with on your behalf:_____

.....

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's or representative's signature on this acknowledgement but did not because:

It was an emergency treatment	_____
I could not communicate with the patient	_____
The patient refused to sign	_____
The patient was unable to sign	_____
Other (please describe)	_____

_____

Signature of Privacy Officer